THE SOCIAL WELFARE FORUM, 1959

OFFICIAL PROCEEDINGS, 86TH ANNUAL FORUM
NATIONAL CONFERENCE ON SOCIAL WELFARE
SAN FRANCISCO, CALIFORNIA, MAY 24–29, 1959

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The National Conference on Social Welfare

THE NATIONAL CONFERENCE ON SOCIAL WELFARE, a voluntary association of individual and organizational members, has since 1874 provided a national forum for social welfare.

The annual forums furnish a two-way channel of communication between paid and volunteer workers, between social work and allied fields, and between the functional services and the profession.

In addition to the annual forums, the National Conference serves as a clearinghouse of basic educational materials for use on local, state, national, and international levels.

The Conference has a comprehensive publications program, and provides services to the state and international conferences on social welfare.

Foreword

THE PROGRAM COMMITTEE FOR THE 86th Annual Forum of the National Conference on Social Welfare planned well. Out of their efforts there emerged around the theme "New Knowledge —Consequences for People" a significant and penetrating presentation on items of critical urgency, affecting individuals, communities, the nation, and the world. Indeed, these issues at this time constitute an agenda of concern for legislative bodies from Congress down to the municipal council, for the policy-making bodies of private agencies, as well as for practitioners. Certainly, the concentration of the program on medical care on Wednesday, May 27, brought forth insights that provided the 4,500 participants in the Conference with guideposts for the great debate that is encompassing the nation as this Foreword is being written.

With unusual faithfulness to a theme, many of the papers introduced the new information, the "fresh, bold approaches," and the "growing edges of knowledge" that were sought by the Program Committee in its charge to the participants. Within this framework contributions were made by historians, economists, physicians, and sociologists as well as by practitioners in the social welfare field.

Assessing the "growing edge," the Conference Proceedings reflect the accelerated growth of the role of the services of public agencies and the cumulative imprint of public policy on the services of private agencies. Times being what they are, the international dimension of interest revealed is not surprising. A door was opened on a substantial part of the world that has been half hidden by confusion brought on as much by the absence of information as other factors. Planning, administration, and research tools that keep the growing edge vital are underscored in many of the presentations.

At best, this volume can only introduce the essence of the con-

cerns of the total Conference. It incorporates in the judgment of the Editorial Committee some of those papers that gave significance and pertinence to the Forum. The limitations of space precluded the inclusion of others. Fortunately, many of these presentations not incorporated in the official Proceedings will be published in the volumes *Casework Papers, 1959, Work with Groups, 1959,* and *Community Organization, 1959.* Some of the papers dealing with particular areas of interest and practice have been accepted for publication in professional journals.

Reading and selection of the material for this publication was a demanding task. Yet it was made rewarding by the wisdom, courage, and soundness of judgment of my colleagues on the Editorial Committee: Gordon Hamilton and Walter Friedlander. My thanks to them for their effort and contribution. Appreciation and thanks are due to Mrs. Eula Wyatt, member of the Conference staff, whose services aided the Committee immeasurably; and to Mrs. Dorothy M. Swart, of Columbia University Press, our competent and understanding editor. Because the guidance and assistance provided by Joe R. Hoffer were so helpful, special thanks are hereby noted.

EMANUEL BERLATSKY
Chairman, Editorial Committee

August, 1959

National Conference on Social Welfare Awards

THE NATIONAL CONFERENCE ON SOCIAL WELFARE AWARDS for outstanding contributions in social welfare were presented by Robert H. MacRae, President of the Conference, at the General Session on Monday evening, May 25, 1959, in San Francisco. The recipients were selected by the Executive Committee on the basis of nominations received from Conference members, the Associate Groups, and State Conferences of Social Work.

The two recipients and their citations were as follows:

For her creative contributions to the growing national concern for the welfare of older people. Her philosophy, rooted in years of practical experience, has significantly influenced thinking and practice in all fields of health and welfare. Furthermore, her influence has extended far beyond social welfare circles. Her opinions are heard with respect, and her advice is sought by representatives of industry, business, labor, government, medicine, psychiatry, education, and architecture. Long before others were showing evidence of interest in the needs of the aged, she initiated pioneering work in the development of services under the auspices of the Community Service Society of New York. The range of these services reflected the breadth of her imagination as it touched housing, casework, and research. She was, in addition, a prime mover in the establishment of the National Committee on Aging of the National Social Welfare Assembly and currently serves as its Vice Chairman. Her creative concern has enriched the lives of our aged citizens. Social welfare acknowledges her leadership with appreciation and admiration—Miss OLLIE A. RANDALL, of New York City.

For her outstanding service in strengthening inter-American relations in the field of social welfare. Over a period of years she

has contributed creatively to the development of social work in other American republics. Not only has she encouraged workers from these countries to come to the United States for training, but she has also assisted our sister republics in the development of their own training schools. She has been imaginative in understanding and interpreting the broad role of social services and social workers in problems of economic development, in housing, and in the improvement of living conditions in rural areas. She has given notable service as advisor to the United States representative of the Economic and Social Council of the Organization of American States. Her capacity for effective leadership was reflected in the presidency of the American International Institute for the Protection of Childhood, and as a mark of esteem she has been named Honorary President of that organization. Her contributions to the well-being of the people of Latin America are beyond calculation. The National Conference on Social Welfare recognizes these contributions with warm appreciation as a reflection of the finest idealism of the social welfare movement—Mrs. Elizabeth Shirley Enochs, of Washington, D.C.

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THE SOCIAL WELFARE FORUM, 1959

New Knowledge—Consequences for People

by ROBERT H. MacRAE

WE LIVE IN A TIME OF TROUBLES. Some have called it the age of anxiety. Others have termed it a period of world revolution. The time in which we live is all of these things. Yet, it is also an era of enormous creative activity. This is not a surprising consequence of troubled days. Tranquillity seldom stimulates vigorous creative achievements.

The growing edges of knowledge in medicine, in physical and social sciences, and emerging developments in political and social organization all have their implications for social welfare. A national conference on social welfare is an appropriate occasion to begin the assessment of these implications. Unifying the 1959 Annual Forum is the examination of some of these developments which reflect social welfare's reaction to the new knowledge available to us. We shall also need to review the impact of new knowledge and new technology which are not enriching human welfare.

"New Knowledge—Consequences for People" is an exciting theme. It is timely and significant. Yet, the subject is so broad and far-ranging that it defies adequate treatment in a brief statement. It is a theme for a book rather than for a presidential address. It is possible, however, to isolate several pertinent issues and to speak of them briefly.

The accumulation of impressive amounts of fragmentary knowledge is the inevitable result of a period of intense intellectual activity. A carefully recorded bit of research here, a sudden insight there, momentarily illuminate a dark corner of the human mind. Like fireworks in a summer sky there is a brilliant, fleeting display

until the rocket sputters out. Steady and pervasive enlightenment must await another development—the process of synthesis. Before much of the fragmentary knowledge can be of great service it must be touched by the kind of mind that can combine the separate elements into an organized whole. Of course, in any vital area of human knowledge synthesis goes on continuously. There are occasions, however, when the process must be accelerated. It would appear we are at the threshold of such a period now. Synthesis involves more than a study of curriculum, however necessary that may be. Synthesis is the product of comprehensive learning, mastery of content, and long reflection. Achieved, in short, it is wisdom.

Can we seriously question the need for such a synthesis in social work? I think not. As a profession we have borrowed freely from psychiatry and psychoanalysis, from anthropology and sociology, from political science and social psychology. Our eclecticism is commendable. Yet, this knowledge must be made uniquely our own. This is an integrative process which is now due. Can social workers bring about this synthesis? The problem requires both scholars and statesmen. Relatively few social workers have qualified as scholars. We are doers rather than thinkers. The zeal for service and the demands for that service have taken precedence over reflection. Perhaps a more significant deterrent to scholarship, however, is the image we have of ourselves. Our very eclecticism, our habits of intellectual borrowing, have left us confused and uncertain about our professional status. Furthermore, we operate in a society which has mixed emotions about social work as a profession. We do not generally command the respect accorded educators, physicians, and the clergy. We are symbols of society's failures, and our very presence is an uncomfortable reminder of those failures. This lack of status critically affects our own estimate of ourselves. Charlotte Towle has expressed it well:

> Perhaps it might be said that in some professions the student is under the stress of approximating the ideal which the community has of him. In social work the student must find within his profession his ideal of himself and must struggle not merely to attain it but to contend for the profession's ideals in a world which frequently contests them. He

must prove not only his own worth as a professional person but his profession's worth as a profession.[1]

Although the heritage of our profession provides a predisposition toward synthesis, we cherish it all too little. The history of social work reflects a recurrence of fads and follies. We have had our quota of easy answers and simple panaceas. In our enthusiasm for the new we have abandoned time-tested methods only to see them return under the auspices of some other profession.

Generally speaking, in other words, we do much to keep ourselves uncertain and confused. We find it difficult to be either scholars or statesmen. We might recall St. Paul's observation: "If the trumpet gives an uncertain sound; who shall prepare himself to the battle? So likewise ye, except ye utter by the tongue words easy to be understood, how shall it be known what is spoken? For ye shall speak into the air." [2]

This generation of social workers is called to the task of synthesis. If it is not done, the sound of our trumpets will remain uncertain. We will merely continue to rummage in the intellectual cupboards of other professions rather than build our own. Our fragmentary chunks of knowledge will continue to lack the integrating touch which makes them uniquely our own. In short, we will not be a profession in the full sense of that word.

The impact of floods of new knowledge expresses itself in yet another way. We live in a scientific age. We too must be scientific! It is true that most of our intellectual borrowing reflects our eagerness to serve people more effectively. It is also a reflection of our desire to give social work the respectability of a scientific discipline. In many ways this is commendable. We wish to escape, and rightly so, from the silly sentimentality of an earlier period in social work. In the process, however, we must not fall into a cold, impersonal discipline which extinguishes the fire and warmth of the best social work practice. We must not elevate technique to a godlike status. Social work is an intuitive art. Like other arts it has a scientific base in principles hammered out of observation and ex-

[1] Charlotte Towle, *The Learner in Education for the Profession* (Chicago: University of Chicago Press, 1954),

[2] I Cor. 14:8–9.

perience. Like other arts it must keep these scientific elements under control so as not to confuse means with ends. The physician is carefully trained in physiology, anatomy, and biological chemistry. At the same time, he does not forget the significance of a warm bedside manner in the healing process. A precept of Hippocrates is still quoted today: "Some patients recover their health simply through contentment with the goodness of the physician." Social work needs to take this insight to heart. We fall into serious error when we define modern science as pure objectivity, totally untouched by intuition or recognition of the human equation. Such a concept is fantasy, and it is fictional. When it is applied in the field of human welfare it results in quick generalizations which set limits on the potential of human beings. Institutions for the chronically and mentally ill are crowded with people who have been declared hopeless on the basis of "scientific" judgment. Can we as social workers surrender all responsibility for struggling with what others have called "impossible?" Our commitment to human welfare demands that we listen to the prompting of the heart. The secrets of success are in the heart as well as in the mind.

Another result of our search for scientific respectability is the increasingly rigid control of our moral indignation—in my judgment, an all-too-rigid control. If the price of scientific advance is cold and detached professionalism, then the price is too high. In truth, scientific training exacts no such price. Even the traditionally detached physical scientists now recognize the interaction between the observer and the observed. They are no longer unconcerned with moral and social values. If the world ever did permit them that luxury it no longer does, since the discovery of atomic fission. For many years social work served as the social conscience of the community. We no longer perform this vital function with the same zeal. It is true that the more gross manifestations of poverty and exploitation no longer exist in this country to the extent they did fifty years ago. Nevertheless, no one is better aware than the social worker of the poverty which flows from deprivation, discrimination, and callousness. And yet, our voices are all too seldom heard in protest or in clarification of the big issues of human welfare. Even more rarely do we go beyond deploring to suggest plans

for constructive action. The capacity for moral indignation is an essential part of the equipment of every social worker. This indignation will not express itself in ranting. It will recognize the discipline of facts, but it will not forget the illuminating power of passion. Do we fear we will lose respectability if we protest social evils? Do we put our concern for fund raising ahead of our concern for human needs? If we answer these questions in the affirmative, then we have failed to maintain the ideals of social work. It might be well for us to recall Montaigne's cryptic observation: "Prudence has its own excesses, and it has no less need of moderation than folly."

The sum total of the enormous increase in knowledge is beyond our comprehension. The result is a higher degree of specialization than at any time in human history. Specialization is not only necessary, it also makes possible tremendous contributions to human welfare. At the same time, we need to be continuously alert to its limitations. The economics of life say "specialize or starve." Specialization, on the other hand, can lead to distorted perspectives, and an inability to communicate outside one's specialty. Some segments of social work practice seem to be arriving at that unhappy stage. Nevertheless, the drive for professional identity within specialized processes continues at an accelerated rate without the forging of essential connective links. At the same time, we are beginning to see the emergence of a belief that we must have a much higher degree of integrated effort if communities are to deal effectively with their most perplexing social problems. We already have at our disposal more knowledge than we use. We know much better than we do. Consider the stubborn social problems which trouble our generation—mental illness, juvenile delinquency, rehabilitation of the physically handicapped. Consider the grave problems of chronic illness and adequate care of the aged. We already possess great stores of knowledge on these questions. We lack maximum effectiveness in dealing with them because we have not yet committed ourselves to concerted effort.

A single multiproblem family may find itself the subject of the ministrations of a half dozen agencies working entirely independently. After a period of bewilderment that same family may de-

volop a kind of cunning which enables it to manipulate the workers on the case. Meanwhile, it remains a multiproblem family. Rather than more research, we need a will and a skill to implement genuinely integrated effort.

I am not proposing a one-stop, supermarket kind of agency. I am proposing devolopment of a structure which furthers cooperative effort by means of a number of professional skills. In such a structure there will be a sharing of knowledge about the multiproblem family, determination of a diagnosis, assignment of responsibilities for treatment, and a continuing communication. Some of treasured agency sovereignty must be yielded for the sake of the larger good of the client. Is this utopian? I think not. Demonstration projects have indicated bright promise in concerted attacks on the multiproblem family by case workers, community organizers, group workers, schoolteachers, physicians, clergymen, and police officers. It is essential that there be a structure through which all these specialties can make common cause. The demonstrations also reflect the clearly evident need for a social work generalist who can bring the relevant specializations into coordinated effort. This is not a blinding new insight. The effort to translate it into operating program is relatively new. The inherent difficulties of the task are obvious. Perhaps the greatest difficulty, however, lies in finding the staff generalists who can achieve articulation of the objectives and make the system work.

In recent months several of my colleagues have been attempting to think through this problem of social organization. Some of us began with the belief that there should be a new social work discipline to place alongside the other specializations. We are no longer of this opinion. We do believe, however, that social work education must lay more stress on the comprehension of basic values. We seriously question if it is valid to assume, as we do, that every social work student genuinely understands the basic value declarations underlying our social system. The gloriously rich Judeo-Christian heritage with its emphasis on the dignity and worth of the individual underlies social work practice. These principles have been stated in such deceptively simple language that we assume a ready comprehension. Yet, it seems apparent they are

largely meaningless phrases to many young people entering social work training. We believe our basic values must be made more vivid and meaningful if our schools are to produce workers of effective competence.

In our discussions we also came to a firm conviction that professional education must stimulate a much higher degree of synthesis of content. We are seeking the development of the capacity to move freely from the microscopic to the telescopic view of social problems. We need workers able to note both individual pathology and the epidemiology of that pathology. With these observations in hand they should be stirred to seek pathways from pathology to prevention.

We came to believe our generalist must be one who could make imaginative use of available skills for helping people by lifting those skills out of the rigidities of existing agency structure if necessary. This implies an ability to find ways of working within the social life of the community, rather than limiting service to the familiar setting of the agency as now organized. While the generalist must possess a clear theoretical and philosophical framework as his guide, he will be able to mobilize a variety of techniques in his practice.

These are broad generalizations. They reflect the effort of our discussion group to define a problem and to develop a new professional response to that problem. They can be summed up in the statement that society needs both generalists and specialists. The generalist is the man who is free to speculate beyond the sharply focused knowledge of the specialist. The generalist relates and capitalizes the insights of the specialist. It is the generalist whose speculations and insights are essential correctives in a society composed largely of specialists. He saves us from blindness in a cave of our own digging and keeps our horizons wide. Clemenceau once remarked that war was too important to leave to the generals. I think it would be well to concede that social work practice might profit by a number of alert, inquisitive, and even annoying generalists in our midst.

I would also appeal for the nonconformist as a generalist at large. The vitality of a society can largely be measured by the ex-

tent to which there is constructive meddling with the status quo. James Harvey Robinson was heard to remark that man rose from the ape because, like him, he kept "monkeying around." Our "monkeying around," however, has led to a glorious array of human achievements. The Fifth Symphony, *Hamlet,* the Constitution of the United States, Pasteur's germ theory, and the evolutionary hypothesis are results of creative "monkeying around." I would even record our indebtedness to the consummate villains of history whose villainy gives us fresh appreciation of the noble and exalted manifestations of the human spirit. In a day which puts high premium on conformity, we must not lose sight of the enormous social value of the inherently curious man who "monkeys around." Long may he live! May his tribe increase!

This is an exciting—if dangerous—time to be alive. The new insights and understanding provide us with tools never before available to the helping professions. The opportunities for conquering age-old diseases, for enriching human life and utilizing its full potentials, are more nearly in our grasp than ever before. Giant strides have been made in eliminating poverty. Stubborn diseases are in retreat. Skills of government are increasing. Only the blind or misanthropic could deny the gains new knowledge has brought to us. Yet, it is important to examine our own attitudes and reactions as we struggle for mastery of this growing knowledge. Hence, my admonitions, which are not for social work alone. Other helping professions contemplate similar problems.

Let me now turn from the internal concerns of social work practice toward society at large. New knowledge has given rise, as we know, to an extensive technology of awe-inspiring complexity. Less and less hard labor is required to earn the necessities of life. Intricate machines not only reduce the need for physical toil but also reduce the hours of labor. As industry moves toward more and more automation the moral discipline of work is lost for millions of workers. At the same time, there is an accompanying depersonalization of man in huge industrial organizations. The social effects of these trends should and must be a concern of social welfare. A good society cannot survive without effective moral disciplines. A fully depersonalized society is an ant-hill society in which conform-

ity and submergence of the individual are carried to their logical conclusion. This we must resist with fanatical devotion.

Now this is not to say that we advocate a return to the spinning wheel and the twelve-hour day. We welcome the machine which relieves men from long hours of toil for sheer existence. We welcome this new freedom which provides opportunities for a fuller life. We are concerned, however, as to how this freedom will be used. Will it be used in harmless but essentially meaningless recreation, or will it be use for the enrichment of life? These are the questions which should trouble us.

Much of our thinking about increased leisure time is devoted to programs for play. Hunting, fishing, golf, bridge, and stamp collecting are wholesome pastimes in reasonable proportions. They are not, however, guaranteed to give a man or woman the satisfaction of being a socially useful contributor to society. They are not foundations on which to build a life purpose. These additional hours of leisure, after a reasonable time for recreation, must be made available for socially useful purposes. Certainly, one of the tasks of social statesmanship in our generation is the mobilization of this huge manpower reserve to carry out useful volunteer tasks. Social work is one of the outlets through which this human energy can be channeled. If it is to be done successfully we shall need to do some hard thinking, toward more important goals than that of merely providing busy work for idle hands.

Social work has always been short of manpower. Perhaps it always will be. We are approaching a time, however, when an abundant supply of volunteer manpower will become available. We must have the skill to claim it. This will require some sharp changes in our thinking. Volunteer service in social welfare has been a traditional occupation of middle- and upper-class people, primarily women. Increasingly, we shall need to provide opportunities for significant service from people of small means, the John Smiths of society. We who talk so easily of the dignity of man and of labor must now demonstrate our capacity to give the fine phrases substance. This comes at a time when we are becoming more and more self-conscious in our professionalization. Yet, it seems to me, the maturity of our professionalization will be ex-

pressed in a capacity to separate the genuinely professional content of our jobs from the nonprofessional. Our maturity will be expressed in the ability to give thousands of humble people satisfying opportunities for community service.

How shall we do it? No simple prescriptions will be provided on demand. In community organization the community development workers have pointed the way. Community development programs need not be restricted to Greece and India. American communities provide ample opportunities for social inventiveness. Some observers question the capacity of democratic government to survive in a meaningful way in enormous urban centers. Certainly, the individual citizen is inclined to feel ineffective and helpless in a great city. The strength and viability of the democratic process may well depend on effective diffusion of the decision-making process through new channels for citizen participation. It is here the community organizer may develop opportunities for the exercise of citizenship through neighborhood organizations. The other specializations in social work must find their own way. It will require a new evaluation of volunteer service beyond the level of stuffing envelopes or acting as a hostess at annual meetings. It will also require imagination in opening up opportunities for service that at the same time fully preserves as professional that which is professional. The gains from this effort will be twofold. Not only will it channel into social welfare vast new manpower resources, but at the same time it can provide for hundreds of thousands a sense of significance which highly mechanized jobs no longer provide. This can be part of our answer to the depersonalization of man in the twentieth century. We can lift him out of the ant heap into the dignity which is rightfully his. We can build a fellowship which will give his life meaning and purpose as he contributes to the making of a better society. Government, the arts, education, will be seeking him also. I would like to think that social work with its sensitivity to human values could give the necessary social leadership to an effort of such tremendous importance.

The violent times in which we live have brutalized all of us. We do not wince at the thought that a single bomb may kill hundreds of thousands of men, women, and children. The vision of it does

not make us ill. We show no penitence over our collective sin. Where are the tender sensitivities which once motivated us? Have we lost the capacity for an uneasy conscience? These are hideous thoughts to contemplate. The horror of all this is not that men will die in the violence of war, for we shall all die eventually. Our system of values has for generations held that individual human personality is sacred. In theological terms we have viewed the human personality or soul as made in the image of God. The horror is that now, in our collective hatred and violence, we have come to regard human beings as mere targets to be destroyed in job lots.

This callousness is a negation of the ideals of social welfare. Its continuance is cancerous. I urge the renewal of our sensitivities. I suggest the earnest cultivation of an uneasy conscience. It is a leaven which each of us can contribute to the social loaf.

It is difficult to have faith and optimism in a period of high tragedy. Moral controls have fallen behind in the rapid pace of mastery of the physical world. Nevertheless, I am an optimist; perhaps incredibly so. Biological evolution may have reached its end in the human animal. I am persuaded, however, that slowly and painfully the evolutionary process continues in the spiritual realm. It is here that we are still primitive beings who do not walk erect as men. Only as we grow in the domain of the spirit shall we find the moral controls for our ingenuity for self-destruction. I think we can grow in spiritual stature if we will. The old order is giving way. The new order is in painful birth. I covet for social work the wisdom and the readiness to aid in the building of that new order.

Stability in the Midst of Change[1]

by SEYMOUR MARTIN LIPSET

MUCH HAS BEEN WRITTEN about social change and conformity in American society. I think that the arguments concerning changes in the direction of greater conformity are exaggerated, and that in a number of areas there has been less change than many of us either fear or like to think has happened over the past century, or even past half century.

Some of you may know of the Herbert Goldhamer and Andrew Marshall study of rates of psychoses over a one-hundred-year period. They analyzed the rates of admission to mental hospitals in Massachusetts to test the usual assumption that the strains of modern industrial and urban life have resulted in higher rates of psychoses. To the surprise of many people, they found no change in a century.[2] This finding, alone, should make those who like facile generalizations about social change uneasy. And Daniel Bell, now of the Sociology Department of Columbia University, has closely examined the evidence bearing on the popular assumption that there has been an increase in rates of crime and violence within large urban centers over the past decades concomitant with a change in racial composition, and the flight of the middle class to the suburbs. He shows that there is actually "much *less* crime and violence . . . than was the case twenty-five and fifty years ago. Certainly Chicago, San Francisco, and New York were much rougher and tougher cities in those years." Bell accounts for the fact that many people believe there is more crime and violence today by the fact that in the past "violent crime, which is usually a lower-class

[1] This paper was presented as an Eduard C. Lindeman Memorial Lecture under a grant of the William Whitney Foundation.

[2] Herbert Goldhamer and Andrew Marshall, *The Frequency of Mental Disease: Long-Term Trends and Present Status* (Santa Monica, Calif.: Rand Corp., 1949).

phenomenon, was then contained within the ecological boundaries of the slum; hence one can recall quiet, tree-lined, crime-free areas and feel that the tenor of life was more even in the past." [3]

Similarly, my own researches on the available data dealing with religious practice challenge the commonly held thesis that America is currently at a high point with respect to religious activity.[4] For example, between 1850 and 1950, each U.S. Census reports approximately one clergyman per 1,000 persons in the population. Another area in which we have reliable statistics which challenge popular and academic conceptions about rates and direction of change is social mobility. Studies which have compared changes in rates of upward and downward mobility over a forty-year period report little difference, when variations in the opportunity structure (changes in types of available occupations) are held constant among the total population; and the various surveys of the backgrounds of the business elite also indicate relatively little variation in their background, other than differences congruent with shifts in the total occupational structure. The proportion of lower-class persons in the upper echelons of business is about the same today as it was in Horatio Alger's day; if anything, the changes are currently slightly more in favor of those of low-status origins.[5]

To point up areas of little change in American culture does not mean that I am arguing that our society is basically static. Clearly, there have been great secular changes—industrialization, bureaucratization, and urbanization—which have profoundly affected other aspects of the social structure. And many American sociologists have documented changes in work habits, leisure, personality, family patterns, and so forth. But this very concentration on

[3] Daniel Bell, "The Theory of Mass Society," *Commentary*, XII (1956), 82; the original detailed account by Bell of his research in this area was published as "What Crime Wave?" *Fortune*, V (1955), 96–99. In 1910, with a population of 4,707,000, New York City had 10,914 juveniles under sixteen arrested. In 1957 when the population of the city was about 7,800,000 only 9,882 juveniles were arrested. The figures were actually much lower between 1920 and 1950, periods characterized by relatively low in-migration rates by ethnic minorities, and rose sharply during the late 1950s. See table "Juvenile Arrests," New York *Times*, March 30, 1958, p. 72.

[4] Seymour M. Lipset, "Religion in America," *Columbia University Forum*, II (1959), 17–21.

[5] Seymour M. Lipset and Reinhard Bendix, *Social Mobility in Industrial Society* (Berkeley: University of California Press, 1959).

the obvious social change in a society that has spanned a continent in a century, that has moved from a predominantly rural culture in 1870 to a metropolitan culture in the 1950s, has introduced a fundamental bias against looking at what has been relatively constant and unchanging. An understanding of the relatively stable basic values of the society may clarify the long-term processes of change in other areas. Two basic values, equalitarianism and achievement, are dominant in American culture, and they are now, as they have been in the past, expressed in various institutional structures. Though they manifest certain contradictory features, neither prime value seems to be weakening. The value of equalitarianism still largely determines the nature of our status system; and, in spite of dire predictions that the growth of large-scale corporations meant a decline of upward mobility, and a consequent fall in achievement motivation, American society, as I have already indicated, is still characterized by a high level of actual achievement, in the population as a whole, as well as within elite groups.

The feature of American life which most impressed foreign visitors in the nineteenth century was the way in which Americans behaved toward each other. A summary of the writings of hundreds of British travelers in America before the Civil War reports:

> Most prominent of the many impressions that Britons took back with them [between 1836 and 1860] was the aggressive egalitarianism of the people. . . . Travellers could see no distinction between the clothes worn by the various classes. . . . Clerks wore as fine a broadcloth as their employers.[6]

Frances Trollope, visiting in America in 1830, complained about that "coarse familiarity, untempered by any shadow of respect, which is assumed by the grossest and the lowest in their intercourse with the highest and most refined," [7] while her equally conservative son, Anthony, visiting thirty years later, objected that "the man whose service one is entitled answers one with determined insolence." [8]

[6] Max Berger, *The British Traveller in America, 1836–1860* (New York: Columbia University Press, 1943), pp. 54–55.

[7] Frances Trollope, *Domestic Manners of the Americans* (London: Whittaker, Treacher and Co., 1832), p. 109.

[8] Anthony Trollope, *North America* (New York: Alfred A. Knopf, 1951), p. 77.

As would be expected, Harriet Martineau, a sympathizer with republican institutions, evaluated the same phenomenon quite differently than did the conservative Trollope:

> The English insolence of class to class, is not even conceived of, except in the one highly disgraceful instance of the treatment of people of colour. Nothing in American civilization struck me so forcibly and so pleasureably as the invariable respect paid to man, as man.[9]

Similar observations were made by the two most well-known foreign commentators on nineteenth-century society, Tocqueville and Bryce:

> Equality of conditions turns servants [workers] and masters into new beings, and places them in new relative positions.[10]

> There is no rank in America, that is to say, no external and recognized stamp, making one man as entitled to any social privileges, or to deference and respect from others. No man is entitled to think himself better than his fellows, or to expect any exceptional consideration to be shown by them to him.[11]

Even today this contrast between Europe and America with respect to patterns of equality in interpersonal relations among men of different social positions is striking. What impressed the typically conservative and upper-class European travelers in the past has also deeply affected the high-status Europeans who have come to America in recent years as political refugees from Nazism and Communism. As one commentator put it:

> With his deep sense of class and status, integration in American society is not easy for the emigré. The skilled engineer or physician who, after long years of interneship, flunking license exams, washing dishes or laboratory floors, finally establishes himself in his profession, discovers that he does not enjoy the same exalted status that he would have had in the old country. I met several young Croatian doctors in the Los Angeles area who were earning $25,000 to $35,000 a year, but still felt declassed.[12]

[9] Harriet Martineau, *Society in America* (New York: Saunders and Otley, 1837), II, 168.

[10] Alexis de Tocqueville, *Democracy in America* (New York: Vintage Books, 1955), II, 190.

[11] James Bryce, *The American Commonwealth* (New York: Macmillan Co., 1910), II, 813.

[12] Bogdan Raditsa, "Clash of Two Immigrant Generations," *Commentary*, XXV (1958), 12. A comparison of reports of European visitors *c.*1890–1910 with those made by British productivity teams also stated that "the foreign descriptions of

And an eminent sociologist at one of the leading universities in the Communist world, when asked at a private gathering what in America most surprised him as compared with his expectations replied without hesitation: "Equality. There just is no country in Europe, Communist or capitalist, in which men treat social inferiors with as much respect, and in which inferiors show as little fear of those higher than them."

The strength of equalitarianism may be seen in the internal structure of many other institutions, such as the family and the school. From the start of our nation, the pressure toward equality penetrated almost everywhere. For example, reports of pre-Civil War British travelers were almost unanimous in commenting on unique patterns of the American family in terms which read like contemporary analyses:

> The independence and maturity of American children furnished another surprise for the British visitor. Children ripened early. . . . But such precocity, some visitors feared, was too often achieved at the loss of parental control. Combe claimed that discipline was lacking in the home, and children did as they pleased. Marryat corroborated this. When a boy refused to obey his mother in Marryat's presence, the father instead of punishing him smiled and commented, "A sturdy republican, sir." The child was too early his own master, agreed Mrs. Maury. No sooner could he sit at a table than he chose his own food; no sooner speak than he argued with his parents. Bad as this might be, countered Thomson, American children were still far more affectionate and respectful towards their parents than was true in British poor or middle-class families. Children were not whipped here, but treated like rational beings.[13]

Harriet Martineau tells how American as compared with English children of the same social class were not afraid to speak up to adults. Her report on child-rearing in Andrew Jackson's day sounds almost too contemporary to be true:

. . . America in 1890 and in 1950 are remarkably similar. . . . The British teams [in the 1950s reported] . . . the same values . . . which impressed visitors a half century ago. Like them they found that the American worker is more nearly the equal of other members of society than the European, with respect not only to his material prosperity, but also to his attitudes, his aspirations, and the attitudes of others toward him." Robert W. Smuts, *European Impressions of the American Worker* (New York: King's Crown Press, 1953), p. 54.

[13] Berger, *op. cit.*, pp. 83–84.

My [parent] friend observed that the only thing to be done [in child-rearing] is to avoid to the utmost the exercise of authority, and to make children friends from the beginning. . . . They [the parents] do not lay aside their democratic principles in this relation, more than in others. . . . They watch and guard; they remove stumbling-blocks; they manifest appropration and disappropration; they express wishes, but, at the same time, study the wishes of their little people; they leave as much as possible to natural retribution; they impose no opinions and they quarrel with none; in short, they exercise the tenderest friendship without presuming upon it . . . . the children of America have the advantage of the best possible early discipline, that of activity and self-dependence.[14]

What struck the democratic-minded Miss Martineau as progressive and beneficial was again interpreted quite differently by such a conservative as Anthony Trollope: "I must protest that American babies are an unhappy race. They eat and drink just as they please; they are never punished; they are never banished, snubbed, and kept in the background as children are kept with us." [15]

The same pattern is reported in the schools. Again how contemporary appears this description of New York area schools in 1833 by a visiting Englishman:

The pupils are entirely independent of their teacher. No correction, no coercion, no manner of restraint is permitted to be used. . . . Parents also have as little control over their offspring at home, as the master has at school. . . . Corporal punishment has almost disappeared from American day-schools; and a teacher, who should now give recourse at such means of enforcing instruction, would meet with reprehension from the parents, and *perhaps retaliation from his scholars.*[16]

Tocqueville too found traces of the American's mistrust of authority "even in the schools," where he marveled that "the children

[14] Martineau, *op. cit.*, pp. 272–73, 279.

[15] Anthony Trollope, *op. cit.*, p. 142. For similar comments see also J. S. Buckingham, *America: Historical, Statistical, and Descriptive* (New York: Harper, 1841), II, 113, and J. Boardman, *America and the Americans* (London: Longman, Rees, Orme, Brown, Green and Longman, 1833), p. 156, who states that children he saw in hotel dining rooms "appeared to be excessively indulged in regard to food, nothing being denied them."

[16] Rev. Isaac Fidler, *Observations on Professions, Literature, Manners and Emigration, in the United States and Canada, Made during a Residence There in 1832* (New York: Harper, 1833), pp. 40–41.

in their games are wont to submit to rules which they have themselves established." [17]

This emphasis on equalitarianism as a dominant feature of American values and behavior, past and present, is seemingly contradicted by the widespread existence of status differences. The American value system has never denied existing differences in rank and authority. But as Tocqueville and others noted, Americans believe that such differences are accidental, not essential attributes of man; and that among men of equal worth it is not good taste to insist on publicly emphasizing the accidental and perhaps temporary distinctions which divide them.

The value of achievement, shown by the strong motivation of Americans to improve their lot in life and by the belief that the most able should be rewarded by high position, is also strongly rooted in American society and may, in fact, be a necessary concomitant of the stress on equality. The emphasis on achievement perpetuates the publicizing of pervasive social mobility: Americans, as compared to Europeans, are more willing to acknowledge their lowly origins. And the belief enables the man of humble birth to regard upward mobility as an attainable goal for himself or his children; while it has fostered in existing elites the persuasion (however mistaken this may be) that its eminence is the result of individual effort, and hence temporary.[18]

The belief in widespread opportunity finds expression in the accounts of the careers of prominent American industrialists and other societal leaders who have climbed to the top. Though there does not seem to be more social mobility in the United States than in Western Europe, it seems probable that the modest social origin of a prominent American is given widespread publicity here, while a comparable background in Europe is more likely to be hushed up or conveniently forgotten. A recent study of social mobility in France suggests this in reporting that:

[17] Tocqueville, *op. cit.*, I, 198.

[18] "Men are constantly changing their situations in life; there is still a class of menials and a class of masters, but these classes are not always composed of the same individuals, still less of the same families; and those who command are not more secure of perpetuity [in the status] than those who obey." *Ibid.*, II, 190–91.

It is precisely among those who have experienced the greatest social mobility that reticence [in the interview] may be of the most significance. One interviewer, commenting on the refusal of an interview by a respondent, adds: "I think it was a question of self-esteem; though he is an industrialist, his father was a white-collar worker, and his grandfather's origins were humble!" [19]

Similarly, British corporation directors are less likely than American executives to report menial jobs in their career histories. A study of the background of such men in England reports that the phrase "training for executive post" was often given by respondents as a characterization of their early occupation, while an American executive would more readily state that he began as a laborer in a mill. This interpretation is supported by another British investigation which gathered data from personnel records rather than from interviews and found many more executives who had begun work in low-status jobs than did the interview study.[20]

The above indicates the self-perpetuating character of value systems. It suggests that an equalitarian value system serves to encourage the publicizing of events which sustain cases of marked upward movement, while where such values are absent, comparable events are left relatively unnoted. But even in a completely egalitarian society, only a few can reach the top of the ladder. What is more important for the average person are his experiences with, and consequent perception of, more modest opportunities for social mobility: the extent to which he sees sons of manual workers and poor farmers becoming teachers, government officials, engineers, clerks, and businessmen.

Perhaps the oldest and most constant source of social mobility throughout American history has been the recurrent waves of mass immigration which brought the depressed strata of Europe to fill economic and social vacancies at the bottom of the structure and

[19] Marcel Brésard, "Mobilité sociale et dimension de la famile," *Population*, V (1950), 535.

[20] See G. H. Copeman, *Leaders of British Industry* (London: Gee and Co., 1955), pp. 92, 137; the Acton Society Trust, *Management Succession* (London: the Acton Society Trust, 1956), pp. 25–27. For an account of the various American studies of the social origins of the business elite see R. Bendix and F. Howton, "Social Mobility and the American Business Elite," in Lipset and Bendix, *op. cit.*, Chap. IV.

thus enabled native-born Americans to rise. The early pre-Civil War foreign travelers in America were struck with the fact that "it was left to the free Negro, the Irish immigrant, and to a lesser extent the Chinese 'coolie' [in California] to be the hewers of wood and the drawers of water. Travelers often wondered who would have built the canals, railroads, and public works if these people had not been around." [21] And Bryce, a half century later, explains the relatively high status of skilled workers by the fact that "all unskilled labourers are comparatively recent immigrants." [22]

It may be argued that for much of American history, low income and status have been the plight of groups which are "in the society but not of it." If these immigrants felt aggrieved with their position in the New World, their natural form of protest was identification with, and organization as, an ethnic group rather than as part of a class-conscious movement which challenged the validity of the American creed of egalitarianism. Moreover, Marcus Hanson and Oscar Handlin, the two major historians of immigration, have suggested that most immigrants accepted the idea that America is a land of opportunity in spite of their personal economic deprivation: the lot of these immigrants was materially better than it had been in Europe, so that they could think of their situation as an improvement even though they were at the bottom of the social ladder in this country.[23]

If mass immigration has contributed to the existence of widespread social mobility and the perpetuation of the American value system, then it may be asked why its ending (as a result of legislation passed after the First World War) did not reduce mobility, and give rise to a native American working class which would have less faith in the "promise of America." Though it may be premature to exclude this possibility as an alternative, the answer lies in two factors: the changing character of the occupational distribution as more of the total labor force is employed in higher paid

[21] Berger, *op. cit.*, p. 58. See also Charlotte Erickson, *American Industry and the European Immigrant 1860–1885* (Cambridge, Mass.: Harvard University Press, 1957), p. 6.

[22] Bryce, *op. cit.*, II, 300.

[23] Marcus L. Hanson, *The Immigrant in American History* (Cambridge, Mass.: Harvard University Press, 1940); Oscar Handlin, *The Uprooted* (Boston: Little, Brown and Co., 1951).

and higher status white-collar, professional, and managerial positions; and the replacement of immigration from Europe by a new pattern of migration within North America which in many ways resembles the old. An expanding economy which still requires new sources of labor has been able to meet these needs by migration from "underdeveloped" parts of this continent to the industrial centers. The new migrants have been, for the most part, Negroes, Puerto Ricans, Mexicans, French Canadians, and, in a different category, poor whites from the rural South.

A large proportion of seasonal farm laborers and sharecroppers come from these groups. Negroes are becoming the central source of relatively unskilled labor in cities all over the country, a role played also by French Canadians in New England, Puerto Ricans in New York, and Mexicans in the Southwest. These 20,000,000 people earn a disproportionately low share of the national income; they have little political power, and no social prestige. They live in ethnic ghettoes and have little social contact with native white Americans, higher up the social scale.[24] The phenomenon of middle-class whites moving to the suburbs is but the most recent example of such a flight from the areas of immigrant settlement. There is little new in the situation except that color as well as ethnicity is involved.

Today as in the past, there are two working classes in America—an upper level composed largely of native Americans; and a lower, less-skilled one which is Negro-Mexican-Puerto Rican—just as two generations earlier it was Catholic-Jewish, East and South European born. A real social and economic cleavage between these different strata diminishes the chances for the development of solidarity along class lines. In effect, the overwhelming majority of native-born whites, both in the working class and in the middle and upper classes, have benefited economically and socially from the continued existence of these ghettoized new recruits to the labor force.

Despite the deprivations experienced by immigrants and minority groups, thus far each group entering the system has been

[24] See Morton Grodzins, *The Metropolitan Area as a Racial Problem* (Pittsburgh: University of Pittsburgh Press, 1959), for a discussion of the growing proportion of Negroes in the central cities of metropolitan areas.

able to move up. In late nineteenth-century America there was a strong occupational differentiation between Catholics and Protestants. Having contributed the bulk of the European immigrants, Catholics were largely in manual occupations, while Protestants were mostly native-born and thus disproportionately in higher status jobs. But today when we compare Catholics whose families have been in this country for three generations or more with white Protestants of comparable background, there is no difference in the occupational structure of the two groups (with the exception that many more Protestants are farmers). This is strong evidence that ethnic and religious groups, as well as individuals, are able to move up in the stratification structure.[25] Even the predominantly native-born Protestant business elite has been opening more and more to members of religious and ethnic minorities. Between 1870 and 1950 the proportion in this stratum with Catholic and Jewish background increased greatly, and the proportion of Anglo-Saxon orgin declined from 87 percent to 65 percent.[26]

While the Negroes, Puerto Ricans, and Mexicans are considerably distant from achieving the equal status of the descendants of European Catholic immigrants, the evidence clearly indicates that even they are on the road upward economically as well as legally and socially.

This emphasis on equality and achievement in the American value system has also been related to, and perpetuated by, the success of the society in producing national wealth. Only on this continent, where the traditionalist values of a feudal agrarian society never held sway, and where an emphasis on economic achievement was supported by other values, was capitalism able to develop in pure form. Here State, Church, and values helped rather than hindered a stress on hard work and efforts at economic advancement. Max Weber attributes this to the strength of Puritan groups in America, since proper conduct for Puritans "was a certain methodical, rational way of life which—given certain condi-

[25] See Lipset and Bendix, *op. cit.*

[26] Suzanne Keller, "The Social Origins and Career Lines of Three Generations of American Business Leaders" (New York: doctoral dissertation, Columbia University, 1953).

tions—paved the way for the 'spirit' of modern capitalism." [27] The economist Joseph Schumpeter and others have attributed American economic growth to the existence of a rich virgin continent and the inpouring of immigrants and capital from Europe, and have viewed the value system as an outgrowth rather than a cause of these economic conditions.[28]

But regardless of its causes, industrialization and advancing technology brought with them an almost unbroken increase in national wealth on both an absolute and a per capita basis, so that in the nineteenth century America became the wealthiest country in the world, a position it has never relinquished. Between 1869 and 1953 per capita income (standardized to 1929 prices) rose from $215 to $1,043.[29] The gross national product increased five times from 1890 to 1950 as a result of a twofold increase in population and a threefold rise in labor productivity.[30]

Particularly significant in the present context are the ultimate social consequences of the growth of American wealth and its superiority over other countries. The distribution of consumer goods has tended to become more equitable as the national income has increased. This, in turn, has considerable effect on patterns of class relations.

A recent American study indicates that the emergence of mass production during the past half century has caused such a redistribution of highly valued prestige symbols that the distinctions in styles of life among social classes are much less immediately visible than they were in nineteenth-century America or are now in contemporary Europe. Gideon Sjoberg points out that with increasing wealth has come a great gain in the income of manual workers relative to many middle-class occupations. He argues that

[27] Max Weber, *Essays in Sociology* (New York: Oxford University Press, 1946), p. 321; see also his *The Protestant Ethic and the Spirit of Capitalism* (New York: Charles Scribner and Sons, 1930).

[28] Joseph Schumpeter, *Capitalism, Socialism and Democracy* (New York: Harper, 1949).

[29] George J. Stigler, *Trends in Employment in the Service Industries* (Princeton, N.J.: Princeton University Press, 1956), p. 25.

[30] Frederick C. Mills, *Productivity and Economic Progress* (New York: National Bureau of Economic Research, Inc., 1952), p. 2.

with a rise in relative income status has come a rise in social status as well. The status difference between skilled workers and at least the lower sections of the middle class has become less well defined, since manual workers, like middle-class people, have been able to purchase goods which confer prestige on the purchaser—clothing, cars, homes, and television sets.[31] Studies by economists point to similar conclusions; for they show that with growth in national income the proportion of income available after taxes has increased faster for family units in the lower than in the higher income groups.[32]

Such improvements in income and style of life undoubtedly help to preserve the belief in equality of opportunity, especially if they occur among manual workers. A man who can buy his own house, or a new car, will feel that he has moved up in the world even if he has not changed his occupational position.

These changes in the distribution of national income imply also that the differences between classes are moderate rather than intense. To a European, different classes mean distinct ways of life with little overlapping of the goods they own or can afford to purchase, even though in many European countries rates of individual mobility across class lines may be quite high. The greater the inequities in rewards in a society, the more the upper classes have the need to erect or preserve a style of life and a value system which legitimate their claim to privilege. The higher strata in a poor society must have psychological defense mechanisms which permit them to be unaffected by the fact that they and their children live well, have servants, and so forth, while the majority of their compatriots live in poverty and are unable to raise their children in a decent environment. In part, this need of such upper classes has been resolved by a value system which defines the lower classes as congenitally inferior, worthless, and even morally corrupted. The upper classes in such societies also preserve almost castelike bar-

[31] Gideon Sjoberg, "Are Social Classes in America Becoming More Rigid?" *American Sociological Review*, XVI (1951), 775–83.

[32] S. Goldsmith *et al.*, "Size Distribution of Income since the Mid-thirties," *Review of Economics and Statistics*, XXXVI (1954), 26. See also Kurt Mayer, "Business Enterprise: Traditional Symbol of Opportunity," *British Journal of Sociology*, IV (1953), 160–80.

riers against interacting with or even seeing lower-class individuals as total human beings who have the same problems as themselves. In America, by contrast, the mildness of such differences in distribution of consumer goods enables the wealthy and poor alike to see differences among the classes as relatively unimportant, as reflecting differences in rewards for greater ability or luck, and encourages many to feel that they can improve their lot. Given an initial strong propensity in the society to stress equality and opportunity, the growth in income to its present proportions has undoubtedly had the effect of reinforcing these values and the behavior flowing from them.

The strong and continuing interest of Americans in equality of opportunity is perhaps nowhere so vividly expressed as in the constant pressures to expand educational opportunities. Almost from the start of the republic, those most concerned with making the phrase "equal opportunity" meaningful pressed for state-supported education.[33] The pre-Civil War European travelers reported that "the necessity of popular education was everywhere regarded as axiomatic. It was the foundation upon which the entire superstructure of American institutions rested." [34]

Since the winning of the fight for the free public school before the Civil War, there has been a steady growth in attendance at primary, secondary, college, and adult levels. By 1954 more than half of all high school graduates continued their education. Today one in four of those in the college age group (eighteen to twenty-one) are attending college, compared to one in twenty-five in 1900.[35]

With such a growth in higher education, it should come as no surprise that college teaching is not only the fastest growing major profession, but the quarter of a million college faculty members

[33] The strength of this egalitarian objective can be seen in the fact that the first and probably only political party to advocate that children be taken away from their parents at the age of six, and raised in state boarding schools, was the Workingmen's Party in New York State in 1830. The party felt this was the only way to guarantee real equality. Nathan Fine, *Labor and Farmer Parties in the United States, 1818–1928* (New York: Rand School of Social Science, 1928).

[34] Berger, *op. cit.*, p. 147.

[35] Department of Health, Education, and Welfare, Office of Education, *Biennial Survey of Education in the United States, 1952–54* (Washington, D.C.), IV–VI, 7–58.

now far outnumber lawyers, physicians, dentists, clergymen, and military officers.[36] These data belie the contention that Americans are not willing to pay for education. In fact, the percentage increase of expenditures on education by American consumers from 1935 to 1948 was far higher than the percentage change in all other categories of consumer expenditure.[37] It may be the very commitment to increasing the number of teachers and schools on every level that prevents teachers' salaries from rising higher. And not only has regular education increased tremendously in response to the American belief that all who qualify shall be educated, but adult education has risen to the point that thirty to thirty-five million people now attend some class on this level.[38]

This impressive growth of opportunities for education concomitant with the growth of bureaucratic and professional employment means that a large proportion of young people have the formal prerequisites to achieve the highest positions in society. Over thirty percent of college graduates in the United States are the sons of manual workers.[39] In providing such opportunities for education, America far outranks every country in the world.

The gradual equalization of educational opportunities in America has had a number of consequences. One already mentioned is the increase in the potential of persons of lower origin to rise in the bureaucracies of government, education, and industry. A second consequence is the reduction in the marked discrepancies which previously existed in the education attainment of manual and nonmanual workers.

A third consequence of mass education concerns its effects on the quality of educational standards themselves. The conservative opponents of the free public schools predicted a serious decline in educational level, and the notion is common today among persons of all political persuasions that the strict regime and discipline of past education resulted in a superior output. But what little evidence exists objectively to test this thesis tends to refute it. Present-

[36] Stigler, *op. cit.*, p. 108. [37] *Ibid.*, p. 44.

[38] U.S. Department of Health, Education, and Welfare, Office of Education, *Fact Book on Adult Education* (Washington, D.C.: Government Printing Office, 1957), p. 4.

[39] Dael Wolfle, *America's Resources of Specialized Talent* (New York: Harper, 1954), p. 162.

day students do as well as, or better than, past generations on comparable examinations in the same subjects even though the schools have been increasingly serving students from lower cultural background and with less intellectual aptitude as the numbers going to school on each level rise.[40]

A fourth consequence of mass education is a higher level of taste and culture among the population. Recent years have seen an extraordinary rise in the sales of classical records, the growth of "serious" radio stations, a shift in paperback sales from "low-brow" to "high-brow" literature, and the emergence of more than a hundred literary magazines, eleven hundred community symphony orchestras, and much greater numbers of little theater groups.[41]

Finally, the results of sociological and public opinion research indicate that education is a liberalizing force per se. The majority of college graduates in the Southern states favor integration of the schools and other institutions.[42] The higher his education, the more likely an individual is to favor equal rights for Negroes and civil liberties for unpopular and extremist minorities and to back other requirements of a democratic political system. The better educated tend to be less xenophobic, more favorably inclined toward internationalist foreign policies and aid to underdeveloped countries. Thus, other things being equal, the growth of mass education seems to be bringing about increasing national consensus, and is helping further to stabilize the democratic process.

While my basic emphasis, the constancy of certain dominant societal values, is supported by a number of observations on American family life—such as the relative weakness of parental authority in the nineteenth century; child-centeredness then and now as reflecting the orientation toward future achievement; [43] the evidence that the double standard of sexual behavior is declining

[40] Research Division, National Education Association of the United States, *The Three R's Hold Their Own at Midcentury* (Washington: the Association, 1951), p. 5.

[41] Bell, *op. cit.*, p. 81.

[42] See Herbert H. Hyman and Paul B. Sheatsley, "Trends in Public Opinion on Civil Liberties," *Journal of Social Issues*, IX, no. 3 (1953), 6–16.

[43] The phenomenon of a marked loss of parental authority which David Riesman describes in *The Lonely Crowd* (New Haven: Yale University Press, 1950), may be viewed as part of a continuing tendency to apply egalitarian norms to all social institutions.

sharply; [44] the growth of equality in husband-wife relations; [45] the ever increasing number of married women who work—there are, however, significant changes in family behavior which do not seem to confirm this basic assumption of value stability, at least within the family.

Perhaps the most surprising change has been the rise of the birth rate. Experts in this field had expected continuation of the long-term decline which has been characteristic of all industrial societies. Rather, the crude birth rate jumped from a low of 16.9 per 1,000 to 25.8 in 1947, reflecting the deferred demand of the war years.[46] Instead of dropping sharply from this high figure as was anticipated, birth rates have continued near the high level of 25.0 during the past decade.[47]

This postwar increase in fertility must be viewed in terms of what had been happening to the American family structure in past generations. While in 1890 the size of the median American family was about five persons, by 1950 median family size had fallen to slightly over three persons.[48] The one-child family had become typical by the beginning of the Second World War, especially in the middle classes. Many population theorists have viewed the desire for upward social mobility as a major factor in explaining this secular trend toward smaller family size.[49]

The earlier decline in the birth rate had been in part explained by the thesis that since the intimate obligations of family relations hold people back in occupational success, there will be a strong tendency in an achievement-oriented society to restrict the family to the smallest unit possible consistent with the performing of its

[44] Alfred Charles Kinsey *et al., Sexual Behavior in the Human Female* (Philadelphia: Saunders, 1953), p. 324.

[45] Ernest W. Burgess and Harvey J. Locke, *The Family* (New York: American Book Co., 1945).

[46] National Industrial Conference Board, *The Economic Almanac 1956* (New York: Thomas Y. Crowell, 1956), p. 15.

[47] U. S. Bureau of the Census, *Statistical Abstracts of the United States, 1957* (Washington, D.C.: Government Printing Office, 1958), p. 56.

[48] Stigler, *op. cit.*, p. 18.

[49] In fact, a number of studies in different countries suggest that lower-status children who come from small families are especially favored in intelligence, opportunity for education, and educational success, all important elements in upward movement. For a detailed summary and discussion of the relevant findings in this area see Lipset and Bendix, *op. cit.*, pp. 238–44, 258.

major function of producing and socializing the young.[50] Given this analysis, the "baby boom" of the fifties suggests the possibility of a decline in the dominant American achievement orientation. However, the increase may also reflect other tendencies. The limited size of many American middle-class families may have involved serious strains and thus induced a reversal of the trend. A solidary family group provides social intimacy and psychic security indispensable to personal stability, and there probably is a point below which the importance and size of the family cannot be diminished. Second, the increasing wealth of the middle class, and the fact that mobility up the bureaucratic ladder, unlike that attained through self-employment, does not require the accumulation of personal savings, may have lessened the conflict between occupational achievement and family size. The recent increase in fertility also reflects the fact that Americans are getting married at an increasingly younger age, a fact made possible by greater wealth.[51]

In recent years persons in better educated and more privileged white-collar occupations increased their birth rates much more than did those in the blue-collar strata. In absolute terms, the lower status groups are still producing more children than the middle classes, but relative to the past, higher-status individuals are contributing a much larger share of today's offspring. Additional evidence that economic security encourages greater fertility is given by a study made during the depression which found that among those who deliberately planned for each child, a large family size was correlated directly with higher income, occupation, education, and value of home.[52]

The trend toward a more familistic culture in the United States is also reflected in the stabilization of divorce rates. In 1900 there were 0.7 divorces for every 1,000 people. Although by 1945 this

[50] Talcott Parsons, "A Revised Analytical Approach to the Theory of Social Stratification," in Reinhard Bendix and Seymour Martin Lipset, eds., *Class, Status and Power, a Reader in Social Stratification* (Glencoe, Ill.: Free Press, 1953), p. 116.

[51] Paul G. Glick, "The Life Cycle of the Family," *Marriage and Family Living*, XVII (1955), 3–9.

[52] Clyde V. Kiser and P. K. Whelpton, "The Interrelation of Fertility, Fertility Planning, and Feeling of Economic Security," in *Social and Psychological Factors Affecting Fertility* (New York: Milbank Memorial Fund), III (1952), 467–548, see esp. p. 489.

rate had climbed to 3.5, there has been a steady decline since the peak reached at the end of the war. The rate had fallen to 2.3 in 1955, still the highest for any major country in the world, but virtually down to prewar levels.[53] The often voiced popular outcry that divorce and marital instability are increasing and constitute a threat to the family system and society would hardly seem to be justified, especially since the trend has increasingly been for divorces to occur in the first two years of marriage, before the birth of children. While the rate as a whole may continue to go down somewhat, a large number of divorces would seem to be one of the prices that must be paid to continue a dynamic, mobile, and individualistic society.

Perhaps the strongest argument for the thesis that the basic values of achievement and equalitarianism have become stronger rather than weaker over the years is the fact that many problems in American life which are the source of considerable anxiety and controversy may be seen as concomitants of an egalitarian and achievement-oriented society. For example, the patterns of status distinction which Lloyd Warner and others (most recently by Vance Packard) have documented and which some have seen as evidence of the decline of equalitarianism were reported in quite similar terms by the various foreign travelers of the nineteenth century. They generally believed, in fact, that Americans were more status conscious than Europeans, that it was easier for a *nouveaux riche* individual to be accepted in ninteenth-century England than in nineteenth-century America. These travelers explained the greater snobbery in this country by suggesting that the very emphasis on equalitarianism in America, the lack of a well-defined deference structure, in which there is no question about social rankings, makes well-to-do Americans place more emphasis on status background and symbolism than is true in Europe:

> It may seem a paradox to observe that a millionaire has a better and easier social career open to him in England, than in America. . . . In America, if his private character be bad, if he be mean or openly immoral, or personally vulgar, or dishonest, the best society may keep its doors closed against him. In England great wealth, skillfully em-

[53] *Statistical Abstracts*, p. 56.

ployed, will more readily force these doors to open. For in England great wealth can, by using the appropriate methods, practically buy rank from those who bestow it. . . . The existence of a system of artificial rank enables a stamp to be given to base metal in Europe which cannot be given in a thoroughly republican country.[54]

The great concern with family background (which generation made the money?) that observers from Martineau to Warner have shown to be characteristic of parts of American society may be a reaction to the feelings of uncertainty about social position engendered in a society whose basic values deny anyone the right legitimately to claim higher status than his neighbor. As the sociologist Howard Brotz has commented in his analysis of the position of Jews in Britain and the United States:

In a democracy snobbishness can be far more vicious than in an aristocracy. Lacking that natural confirmation of superiority which political authority alone can give, the rich and particularly the new rich, feel threatened by mere contact with their inferiors. This tendency perhaps reached its apogee in the late nineteenth century in Tuxedo Park, a select residential community composed of wealthy New York businessmen, which not content merely to surround itself with a wire fence, posted a sentry at the gate to keep nonmembers out. Nothing could be more fantastic than this to an English lord living in the country in the midst, not of other peers, but of his tenants. His position is such that he is at ease in the presence of members of the lower classes and is associating with them in recreation. (For example, farmers [that is tenants] ride to the hounds in the hunts.) It is this "democratic" attitude which, in the first instance, makes for an openness to social relations with Jews. One cannot be declassed, so to speak, by play activities.[55]

Status-striving and its inevitable concomitant of conspicuous consumption have, of course, not solely or even primarily affected the behavior of the more well-to-do classes in American society. Thus, the most recent effort to summarize the reactions of European visitors in the twentieth century to the behavior of American workers notes that the visitors are struck by the "spendthrift pattern of the American worker's life," and that they see this be-

[54] Bryce, *op. cit.*, II, 815. Cf. D. W. Brogan, *U.S.A.* (London: Oxford University Press, 1941), pp. 116 f.

[55] Howard Brotz, "The Position of the Jews in English Society," *Jewish Journal of Sociology*, I (1959), 97.

havior as reflecting "the profound feeling of equality [in America which] urges them to make a show" (Paul Bourget), for as Werner Sombart well put it, "since all are seeking success . . . everyone is forced into a struggle to beat every other individual," and in an egalitarian democracy like America, the ability to spend . . . [is] the only public sign of success at earning" (Hugo Münsterberg).[56]

The problem of conformity which so troubles many Americans today has also been noted as a major aspect of American culture from Tocqueville to Riesman. Analysts have repeatedly stressed the extent to which Americans are sensitive to the judgments of others. Never secure in their own status, they are concerned with public opinion in a way that aristocrats do not have to be. As early as the nineteenth century, foreign observers were struck by the "other-directedness" of Americans and accounted for it by the nature of the class system. This image of *the* American as "other-directed" can, as Riesman notes, be found in the writing of "Tocqueville and other curious and astonished visitors from Europe." [57] Harriet Martineau almost seems to be paraphrasing Riesman's own description of today's "other-directed" man in her picture of the early nineteenth-century American:

> Americans may travel over the world, and find no society but their own which will submit [as much] to the restraint of perpetual caution, and reference to the opinions of others. They may travel over the whole world, and find no country but their own where the very children beware of getting into scrapes, and talk of the effect of actions on people's minds; where the youth of society determines in silence what opinions they shall bring forward, and what avow only in the family circle; where women write miserable letters, almost universally, because it is a settled matter that it is unsafe to commit oneself on paper; and where elderly people seem to lack almost universally that faith in principles which inspires a free expression of them at any time, and under all circumstances.[58]

It may be argued that in a situation of "status anarchy," when people are encouraged to struggle upward, but in which there are not clearly defined reference points to mark their arrival and where their success in achieving status is determined by the good opinion

[56] Quotations are cited by Robert Smuts, *op. cit.*, p. 13.
[57] Riesman, *op. cit.*, pp. 19–20.
[58] Martineau, *op. cit.*, II, 158–59.

of others, the kind of caution and intense study of other people's opinions described by Martineau is natural. Like Riesman today, she notes that this "other-directed" type is found most commonly in urban centers in the middle and upper classes, where people live in "perpetual caution." Nowhere does there exist "so much heart-eating care [about other's judgment], so much nervous anxiety, as among the dwellers in the towns of the northern states of America." [59] Similarly, Max Weber in the early 1900s noted the high degree of "submission to fashion in America, to a degree unknown in Germany" and explained it in terms of the lack of inherited class status.[60]

A society which emphasizes achievement, which denies status based on ancestry or even on long-past personal achievements, must necessarily be a society in which men are sensitively oriented toward others, in which, to use Riesman's analogy, they employ a radar to keep their social equilibrium. And precisely as we become more equalitarian, as more people are able to take part in the status race within the large bureaucracies of the impersonal metropolis, to that extent we become more American in the Tocquevillian sense.

The same point may be made with regard to much of the discussion about the negative consequences of mass culture. Increased access by the mass of the population to the culture market necessarily means a limitation in cultural taste as compared with a time or a country in which only the well-to-do and the well educated have access to the creators of culture.[61] The "Americanization" of European culture which disturbs so many European intellectuals may reflect, not the power of American dollars or diplomacy, but rather the Americanization of the class structure of Europe. The European masses for the first time earn enough money, and have enough leisure, actually to command the course of general culture.

The current debates concerning education reflect the same dilemma, that many who believe in equalitarianism would also like to secure some of the attributes of an elitist society. In England,

[59] *Ibid.*, pp. 160–61.

[60] Weber, *Essays in Sociology*, p. 188.

[61] Smuts (*op. cit.*, p. 11) reports in his summary of the reports of European visitors of the 1890–1910 period that many of them "realized that the 'vulgarity' of American culture was very largely the result of the immensity of the culture market."

where the integrated, "comprehensive" school is seen as a progressive reform advocated by Laborites, the argument for it is based on the assumption that the health of the society is best served by what is best for the largest number. This was true in this country when liberal educators urged that special treatment for the gifted child served to perpetuate inequality, to reward those from better home and class environments at the expense of those from poorer backgrounds. Educators in Britain today argue strongly that separate schools for brighter children, the so-called "grammar schools," are a source of psychic punishment for the less gifted. Many of us have forgotten that liberals in this country shared similar objectives not too long ago, that Fiorello LaGuardia, as Mayor of New York, abolished Townsend Harris High School, a special school for gifted boys in which four years of schoolwork were completed in three, on the grounds that the very existence of such a school was undemocratic, that it gave special privileges to a minority.

What I am saying is very simple: it is a variant of that old maxim that you cannot have your cake and eat it too. You cannot have segregated elite schools in a society which stresses equality; you cannot have a cultural elite which produces without regard to public opinion and mass taste in a society which emphasizes the value of popular judgment; you cannot have a low divorce rate and an end to differentiation in sex roles; you cannot expect to have secure adolescents in a culture which offers no definitive path from adolescence to adulthood.

I do not mean to end on a pessimistic note, or to suggest that we are in an endless vicious circle. In fact, there is considerable evidence to suggest that higher education, greater economic security, and higher standards of living result in strengthening the level of culture and democratic freedom. The market for good books, good paintings, and good music is at a high point in American history. There is evidence that tolerance for ethnic minorities is also at a high point. More people are receiving a good education in America today than ever before. And Daniel Bell, among others, has argued effectively that the growth in education is among the factors which are making for less conformity in American life in mid-century. He points to the fact that "one would be hard put to find

today the 'conformity' *Main Street* exacted of Carol Kennicott thirty years ago. With rising educational levels, more individuals are able to indulge a wider variety of interests." [62]

Others who acknowledge the positive effects of increased education still see a decline in freedom in major areas of American life as a consequence of the growth of the large corporation and the other big organizations—because "organization men" must conform to succeed, and because economic mobility has declined as an alternative road to success since new enterprises are difficult to launch in bureaucratized and often monopolized markets. However, the growth of large organizations may also have the opposite effects. Bureaucratization may be a new source of freedom, since it involves a decline of arbitrary power. Bureaucracy, by establishing norms of fair and equal treatment, and by reducing the arbitrary power which characterizes many nonbureaucratic organizations, has meant less rather than greater need to conform to superiors. And trade unions may accurately reflect their members' desires when they move in the direction of more rather than less bureaucratization. For example, unions have sought seniority rules in hiring, firing, and promotion, which serve to reduce arbitrary power. And unionization, both of manual and white-collar workers, is maximized under conditions of large-scale organization. The trade union everywhere in the economy serves to free the worker or employee from a previous condition of subjection to relatively uncontrolled power. And those who fear the subjection of the worker to the organizational power of unionism ignore for the most part the alternative of arbitrary management power. In many ways, the employee of a large corporation who is the subject of controversy between two giant organizations, the company and the union, has a much higher degree of freedom than has the man who does not work for such a large organization.

There can be no doubt that the tendency toward large-scale organization has served to reduce freedom in some areas, but these days we seem to ignore the extent to which it has maximized it in others. Similarly, some time ago analysts of American society were fond of predicting that the growth of large companies meant a

[62] Bell, *op. cit.*, p. 82. Clyde Kluckhohn has also argued that there is "more genuine individuality in the United States" rather than conformity. See "Shifts in American Values," *World Politics*, XI (1959), 257–59.

decline in social mobility. And while it may be more difficult to build up a multimillion-dollar business from scratch today than in the 1870s, it currently seems no more difficult to reach a high position in the economy from lowly origins than a half century ago. We know a great deal about mobility in American society; but we know relatively little about the effects of the growth of large organizations on equality and conformity. As I have made clear, I am persuaded neither that this is an age of greater conformity nor that it is a period of reduced mobility.

I would like to emphasize again what most of the foreign travelers to nineteenth-century America took for granted, that this country has been the most radical nation on earth in terms of social relationships. The American revolution has not stopped, and should not be judged solely or even primarily by the degree of economic experimentation it fosters. American cultural radicalism consists of breaking down the barriers of class, of inherited background, and in trying to open the doors of real culture to the entire population. If 30 percent of the relevant age population is now attending college, we must remember that most of them come from families in which past generations did not go to a university, perhaps did not even graduate from high school. Although some buy good paintings, records, books, or well-designed furniture in order to "keep up with the Joneses," this pattern means that their children will grow up in homes in which good taste is part of the environment. I do not predict an egalitarian and cultural utopia. Every effort to solve social problems seems to result in unforeseen difficulties. Some values which we hold dear always turn out to be incompatible with others that we seek.

But I doubt whether I am telling social workers anything new when I say these things. Your profession, like the medical profession, is based on the assumption that there are strains which will adversely affect people, and that some professions and institutions must be systematically concerned with relieving and allieviating these tensions. As society moves on, as we cope with various problems, we create others. But problems and conflict and even despair are the lifeblood of democracy; solutions and utopias must be left to the totalitarians.

Unemployment in the Great Depression

by IRVING BERNSTEIN

THE THIRTIES WERE THE HEROIC AGE of American social work. The social worker, like the soldier, achieves his maximum utility in an era of crisis. Social work had theretofore been conducted in an essentially private manner with little public recognition. In the thirties it moved onto a new and much bigger stage. To support this conclusion I offer but two bits of evidence: Federal relief began in the United States in 1932 largely because of the shocking and knowledgeable testimony of a score of social workers on the human cost of unemployment before the Senate Subcommittee on Manufactures. The man in whom President Roosevelt probably reposed most confidence both in the offensive against the depression and in that against the Axis powers was a member of the social work profession—Harry Hopkins.

If historians were asked to name the three events that have had the most profound and lingering effects upon the institutions, the social outlook, and the mood of the American people, I suspect they would choose the Civil War, the Second World War, and the Great Depression. Among all the depressions the United States has suffered, this is the only one we elect to call "great." And with good reason. It was unique.

It was exceptional for three reasons. The first was sheer size. The second was that the American people were unprepared for it. This was in part because they were mainly urban dwellers little more than a generation removed from the farm. The immense pre-1914 wave of immigration to the United States was essentially a movement of the European peasantry. Further, between 1920 and 1929,

over nineteen million persons left American farms for the cities. The farmer knows hard times, but not in the form of unemployment.

The third and, I think, the most interesting explanation for the uniqueness of the Great Depression was that it was overwhelmingly an experience in joblessness. This was new and unexpected. Though there had been many previous economic downturns and some had rather severely affected employment—for example, those of 1873 and 1893—the nation had not consciously viewed them as unemployment depressions. The conventional word was "panic." This referred to a collapse in land values, or a sharp take-out in stock prices, or a threat to the stability of the dollar. Since 1931 the great majority of Americans have thought of the Great Depression primarily, if not exclusively, in terms of joblessness.

Within the green memory of most people in the 1930s there had been no parallel. The more recent economic fluctuations—1927, 1924, 1920–21, 1913, 1907—were of relatively shallow depth and short duration. Some folks could remember the nineties, but only dimly.

This helps to explain Mr. Hoover's failure as a depression President. He insisted that this was simply another panic brought on by the Wall Street crash and the tangled international debt and monetary problems left over from the First World War. He tenaciously refused to recognize that the prime problem was unemployment.

Since the thirties we have come about 180°. We have tended to view each of the post-Second World War downswings in the business cycle as preludes to mass unemployment like that of the thirties. None, fortunately, has brought this result. Once again, this points to the uniqueness of the Great Depression.

We know that the unemployment of the thirties was immense, but we do not and never shall know exactly how large it was. At the time, the art of compiling economic statistics was relatively undeveloped. The first satisfactory index of industrial production was constructed only in the twenties. In 1930, Senator Robert F. Wagner, of New York, introduced a bill into Congress that would have authorized a monthly index of employment. He waited ex-

actly a decade before this series came into being. It was not till after the decennial census of 1940 that the Bureau of the Census began publication of the monthly report on the labor force. It is an irony that at a time when unemployment was our prime problem we failed to count those who were out of work in a systematic and continuing fashion. A cliché of the thirties was that we kept better statistics of the pig population than of the labor force. Hence we know far less about the unemployment of those years than we would like to know.

For the purpose of describing the course of unemployment from 1929 to the Second World War I shall use two monthly series—that of the Committee on Economic Security (which drafted the Social Security Act) until mid-1935, and that of the National Industrial Conference Board for the succeeding period. The impertinence of splicing these series together would never be displayed by a reputable statistician. I suffer no inhibition. The figures that follow will be more meaningful if they are considered alongside the size of the labor force, which grew at a rate of about 400,000 a year from approximately 48 million in 1930 to 52 million in 1940.

Unemployment, which had been a nagging problem in the twenties, became severe immediately after the stock market crash in the fall of 1929. It passed the 4.0 million mark in January, 1930, 5.0 million in September, and 8.0 million in January, 1931. Joblessness exceeded 10.0 million by the end of that year, 12.0 million in March, 1932, and 13.5 million in December. The figures for the first three months of 1933 take the breath away: 14.5 million in January, 14.6 in February, and 15.1 in March. At this time almost one in every three Americans in the labor force was out of work. Many millions more were on part time.

The experience of United States Steel is illustrative. In 1929 the corporation had 224,980 full-time employees. Their number fell to 211,055 in 1930, 53,619 in 1931, 18,938 in 1932, and zero on April 1, 1933. All who remained were part-time workers, and they were only half as numerous as those employed full time in 1929.

March, 1933, the month in which political power passed from Hoover to Roosevelt, was the watershed. The number of jobless in the United States declined fairly steadily to 10.7 million in June,

1934. It then remained at roughly that level for two years. A marked business recovery in 1936–37 reduced unemployment to its low for the decade of about 6.0 million. The recession of 1937–38 led it up again to about 12.0 million. The outbreak of war in Europe in 1939 presaged the liquidation of the problem. Joblessness declined steadily during 1940. By mid-1941 the United States at last enjoyed full employment, actually for the first time since 1923.

These figures hardly indicate the differential impact of unemployment. Some communities and industries suffered almost total devastation, as though they had been visited by natural disaster. In early 1932 coal-rich Williamson County, Illinois, provided almost no employment. In the town of Coello, with a population of 1,350, two persons had jobs. In Benton, 2,000 children had not tasted milk for a year. Donora, Pennsylvania, in March, 1932, had 277 employed out of a population of 13,900. At the height of the season in the men's clothing industry in January, 1932, only 10 percent of the New York City membership of the Amalgamated Clothing Workers was employed. In 1934, the three copper mines in the towns of Globe and Miami, Arizona, shut down. Seventy percent of the population was on relief. The mystery was how the others lived. "Being a proletarian in good standing," Heywood Broun remarked at the time, "is no bed of roses."

Unemployment was most severe in construction, the extractive industries, and manufacturing. The heavy industries, that is, suffered more than the light. The Committee on Economic Security calculated an index of employment by industry group, with the 1929 monthly average considered as 100. In March, 1933, the index for building stood at 18.7; for forestry and fishing, 31.1; for mines and quarries other than coal, 32.5; for manufacturing, 58.2; for coal, 64.4; for wholesale and retail trade, 72.0; for telephone and telegraph, 73.2; and for banking and insurance, 79.4.

Unemployment also had a differential social impact. Those over forty-five and young people entering the labor force suffered more than those in the middle years. In Flint, in 1936, the staff of the relief administration consisted of former General Motors employees. Buick had let them go because they were approaching fifty and

drew high salaries. Walter Pitkin's *Life Begins at Forty* was a best seller for two solid years. Married women with working husbands were under pressure to retire from the labor force. The city of Syracuse, for example, fired 170 women in December, 1931, for this reason. Negroes were subject to the iron law of "last to be hired and first to be fired." In Mississippi, whites with systematic brutality drove Negro firemen out of the locomotive cabs of the Illinois Central. By mid-1933 seven had been wounded, one flogged, and seven murdered. A study conducted by the Federal Emergency Relief Administration in October, 1933, showed that 18.4 percent of the people on relief were colored; yet in the census of 1930, Negroes were only 9.4 percent of the population.

Aliens were discriminated against in various ways. The Hoover Administration sought to curtail the supply of labor by eliminating both foreign and resident aliens from the labor force. In September, 1930, the President, by invoking the "likely to become a public charge" clause of the immigration law, imposed a virtual embargo against those seeking to enter the United States. Secretary of Labor William N. Doak, then responsible for the Immigration and Naturalization Service, launched a vigorous deportation campaign against resident aliens who had entered the country illegally, many of whom he described as "Reds." Filipino field hands were beaten, shot, and denied jobs in California's agricultural valleys. Tens of thousands of Mexicans were shipped back across the border.

Mass unemployment distorted the structure of jobs in the labor market. Workers whose ability and seniority justified promotion found that the better jobs did not exist. On the railroads the fireman and trainman had no opportunity to rise to engineer and conductor. There was a pervasive downgrading of the labor force. As work crews were reduced in size, the highly skilled bumped down into low-skilled jobs. Engineers became office boys. Many employers fired high-wage employees and replaced them at lower rates from the vast pool of the jobless. In the West Virginia coal camps the miners fearfully talked of "the barefoot man"—the "barefoot, hungry man outside waiting for your job."

Voluntary turnover dried up. Almost no one left a job because he was dissatisfied with working conditions. The quit rate ap-

proached zero. The individual wage earner's sole bargaining weapon—the voluntary quit—virtually ceased to exist. Unemployment assured the employer that his employee would love his work.

Unemployment severely strained the American wage structure. Average hourly earnings in bituminous coal mining declined 26.4 percent between 1929 and 1933; in manufacturing, 21.9 percent; and on the railroads, 6.4 percent.

These averages conceal the extremely low wage rates that appeared in growing numbers in 1932 and 1933. Briggs Body in Detroit paid men 10 cents and women 4 cents per hour ("If poison doesn't work," the auto workers said, "try Briggs"). A survey of 355 female department store clerks in Chicago revealed that 294 received less than 25 cents an hour, with over half under 15 cents, one fourth under 10 cents, and 24 under 5 cents. A rate of $1.50 a day for a coal miner in the nonunion fields was common. The Pennsylvania Department of Labor uncovered wages of 5 cents an hour in sawmills, 6 cents in brick and tile manufacturing, and 7.5 cents in construction. Sweatshops in Connecticut paid girls between 60 cents and $1.10 for a fifty-five-hour week. In San Antonio, Mexican women did needlework on baby garments for as little as 20 cents a day. The average daily rate for farm labor without board in the United States in 1933 was $1.11.

A striking feature of the unemployment of the thirties was its relative permanency. When a man lost his job he could generally assume that he would not get it back and would not find another. The recovery of production to 1929 levels, as became dramatically evident in the fall of 1936, would not create full employment. The labor force, as I have already noted, expanded during the thirties, as did output per man-hour. Technological displacement was a ubiquitous source of worry. In 1935–36 an electric crane on the Mesabi Range threw twelve iron miners out of work; a mechanized anthracite operation in Scranton displaced 800 men; a new auto body at Studebaker in South Bend "finaled out" 100; a modern steel mill in Ohio eliminated 1,500 jobs. Steel output in Youngstown in 1936 reached the 1929 level, but 10,000 fewer men were at work.

The economic catastrophe that I have described had an immense

social impact upon the American people. The physical movement of population, historically a response to economic opportunity, was drastically changed by the removal of that opportunity. Joblessness and Hoover's restrictive policy virtually shut off immigration. The great shift from farm to city was significantly slowed. In their stead came transiency, the worker adrift in a sea of unemployment, sailing aimlessly without home port or destination. The transient was in a cruel and ironic sense the hero of the depression epic, the symbol of a floundering America. He was Dos Passos's Vag in *U.S.A.* and Steinbeck's Tom Joad in *The Grapes of Wrath,* the stark, beaten, weathered face staring out of the pages of scores of books and photographs.

It was estimated that there were a million persons on the road by 1933. Many were very young, and there was an unusually large number of women and girls. Theirs was, in the words of the National Resources Committee, "a migration of despair." Their objective was always somewhere else. No one wanted them. Most of the states and cities, overburdened with the relief of their own, passed them on. Their answer to unwantedness was the urban jungle, the junk-pile Hooverville with its Prosperity Road, Hard Times Avenue, and Easy Street.

Transiency emerged because the depression uprooted the family. The pressures upon this institution were severe: unemployment, poverty, social disgrace, and overcrowding. A consequence was social isolation. "The typical [unemployed] family," wrote Mirra Komarovsky, "does not attend church, does not belong to clubs, and for months at a time does not have social contacts with anyone outside the family." Under these forces families responded in opposite ways. Those that were already integrated became more so. Those that were under tension split apart.

The manifestations of breakdown in the latter group were abundant. There were numerous criminal acts: stealing (especially of food), assault, even murder. There was a marked rise in prostitution. In "Middletown" the Lynds found that married women became streetwalkers in order to supplement the family income. In Camden, writer Martha Gellhorn found "a lot of amateur prostitution" by young girls, usually for the price of a beer. Drunkenness,

despite the Eighteenth Amendment, increased. Families who lost their homes often parceled out the children to relatives or friends. Desertions were common.

A family phenomenon upon which many commented was the denigration of the father. The culture demanded that he play the role of breadwinner, and the depression denied him the opportunity. The father who merely washed dishes and made beds lost status in the eyes of his wife and children. Women, especially in the early years of the depression, often refused to believe that jobs were not to be had: something must be wrong with the man.

The number of marriages declined sharply. Young people who planned to wed postponed the date. The marriage rate per thousand fell from 10.1 in 1929 to 7.9 in 1932. The birth rate followed inevitably. The number of births per thousand declined from 20.0 in the late twenties to 16.6 in 1932. Falling reproductivity created our notoriously small "depression generation."

Unemployment took its toll of the nation's health. While money cannot of itself prevent or cure disease, it can buy the things that reduce its incidence—good food, adequate housing, warm clothing, medical care. The fact that a large segment of the population suffered a drastic cut in income was reflected in health. The basic problem was malnutrition and the diseases it caused. "You eat just as much loafing as you do working," Will Rogers remarked. "In fact, more; you got more time."

The Milbank Fund studied the health of 7,500 families in eight cities. The rate of illness in 1932 was nearly 40 percent higher for families with per capita incomes of less than $150 than for those with incomes of $425 or more. The highest sickness rate occurred among those whose incomes had suffered a sharp decline since 1929.

Miss Gellhorn wrote Hopkins from Massachusetts in 1934:

> The Welfare nurses, doctors, social workers, the whole band, tell me that T.B. is on the increase. Naturally; undernourishment is the best guarantee known for bum lungs. The children have impetigo—as far as I can make out, dirt has a lot to do with this. Rickets, anemia, bad teeth, flabby muscles. Another bright thought: feeble-mindedness is on the increase.

The most serious social impact of the Great Depression was upon the morale of the American people. The depression of the mind was more severe than that of the economy. "Society was no longer a comfortable abstraction," Alfred Kazin wrote, "but a series of afflictions." The future ceased to exist.

Leisure became a misery. Young people grew aimless and apathetic, accepting the idea that they would never find jobs. "I generally go to bed around seven at night," a Camden youth told Miss Gellhorn, "because that way you get the day over with quicker." The self-reliant lost their self-reliance. Fear and inactivity were the enemies of mental stability. "I cannot stand it any longer," a jobless Pennsylvanian wrote Governor Gifford Pinchot. Miss Gellhorn wrote:

> Now about the unemployed themselves. This picture is so grim that whatever words I use will seem hysterical and exaggerated. . . . I find them all in the same shape—fear, fear driving them into a state of semi-collapse; cracking nerves; and an overpowering terror of the future. I haven't been in one home that hasn't offered me the spectacle of a human being driven beyond his or her power of endurance and sanity.

A group of forty experienced stenographers called back to work in 1933 after at least a year of unemployment found that they could not face their employers for dictation without breaking down emotionally. Psychiatrists reported a deterioration in mental health. The suicide rate rose from 14.0 per 100,000 in 1929 to 17.4 in 1932.

There were some beneficiaries of this attrition of morale. The churches that specialized in personal solace noted an increase in attendance. The fortunetellers in South Bend enjoyed a boom in 1932. Some newspapers specialized in hard-luck stories on the theory that folks who were having a tough time liked to read about others who were worse off. Billy Minsky devised a formula for the male half of the population: continuous burlesque. "Give the people something else to think about," Billy pronounced. Patrons would enter his Central Theatre in Manhattan in the morning and not emerge until 1:00 A.M. of the following day.

Millions of Americans—the children of the Great Depression—

were to bear the scars of this breakdown in morale for the whole of their lives.

The massive unemployment of the early thirties formed a great divide between two worlds. It wrought a profound change in the institutions, the social outlook, and the mood of the American people. The old order of individualism, private responsibility, business supremacy, and Republican dominance drew to a close. Joblessness created an overpowering yearning for security against the hazards of life, denigrated the business hero and the business system, and more than anything else produced the New Deal.

The reforms of the New Deal were largely addressed to the needs of the unemployed urban worker of the thirties: Federal public relief, unemployment insurance, old age pensions, the minimum wage, limitations on the hours of work, the encouragement of trade unionism and collective bargaining, and a *de facto* Keynesian economics. The presumption was that the American worker should never again suffer the economic and social devastation visited upon him by the unemployment of the thirties.

Are We Spending Enough for Social Welfare?

by IDA C. MERRIAM

OVER THE PAST HUNDRED YEARS this country has doubled its output of goods and services roughly once every twenty-four years. We have taken the fruits of expanding productivity partly in the form of fewer hours of work, partly in greatly increased levels of real family income, partly in a substantial growth of social services. For the first time in history we have the technical means of wiping out poverty. Even in a society of great abundance, however, that possibility cannot be achieved automatically or easily.

The general level of spending for welfare—or for any other purpose—in a democratic society depends in part on the total resources available; in part on the general values of the society and the way in which particular needs are perceived; in part on the existence of institutional mechanisms through which choice can be effectively exercised. Social inventiveness may be as important as technological invention in determining the rapidity and direction of social progress.

While we must all hope and work for the kind of world situation in which military spending in all countries will be cut to a tiny fraction of what it is today, it is probable that for some time to come social welfare spending must justify itself in competition with, or in addition to, a heavy burden of military expenditures. What is the nature of the claim which social welfare can at this time legitimately and effectively make for its share of the national output?

One part of the claim is timeless in character. Underlying all modern welfare programs is the age-old demand for social justice.

Another part of the claim is specifically related to the nature of the world in which we live—its complex technology, its interdependence, its dynamic character. Part of the reason for spending for social welfare is that in a modern, complex urban economy we must do so if the society as a whole is to prosper.

It is accepted without question by those who have worked most closely with the problems of underdeveloped countries that an essential step toward economic development may be improved health and more widespread education for the people of the country. The economists call expenditures for such purposes investments in social overhead capital. Better health and increased literacy or technical training are not themselves enough to start a society on the road toward greater economic productivity. Indeed, at the outset they may aggravate the problem of the number of mouths to be fed and the number of individuals whose talents are not fully used. But without improved health and education other measures will probably fail.

A developed economy requires an even higher level of investment in human resources. Continuing economic growth depends to a major extent on continuing innovation which comes increasingly from highly trained scientists and organized research. The number of jobs for unskilled workers has been decreasing in one field after another, and the new era of automation, atomic power, and space exploration can be expected to continue this process. Higher and higher levels of professional training, as well as more persons with such training, are called for in such fields as medicine and social work.

Broadly speaking, there have been three major stages in the support of education in this country. The first began early in the last century with the then highly controversial decision in state after state that every child should have an opportunity to get an elementary education in publicly supported schools, and the gradual development of compulsory school attendance laws. At the end of the century we were spending a little over one percent of our gross national product on education. With the second stage, the extension of the normal span of schooling to include high school and some vocational training our total public and private expenditures

for education amounted by 1929 to almost 3 percent of the much larger national product.

The third period, when college and postgraduate training became accepted goals for large numbers of young persons, was signalized, if not in a sense ushered in, by the GI educational benefits program. In 1950 expenditures under this program alone amounted to one percent of the gross national product if subsistence payments are included—and certainly many veterans could not have taken advantage of the scholarship funds without some income support. This total raised our educational expenditures in 1950 to about 4.5 percent of our entire national output. Since that time, the GI benefits have fallen off sharply, but other public (and private) expenditures for education have gone up so that today we are spending at a level of about 4 percent. Somewhat over four fifths of these expenditures are from public funds. In spite of the rise in college enrollments, it is estimated that the nation is today losing the talents of as many as 150,000 able young people a year, from the lower income levels, who do not continue their education beyond high school. At the same time, many of the essential professions are undermanned.

Clearly, within the next decade the construction of new school and college buildings, the further upgrading of teachers' salaries, the increasing emphasis on postgraduate education, the probable expansion of scholarship aid, and possibly a new approach to adult education and to special refresher training courses for women who have raised families and are ready to go back into paid employment —these and other trends, together with the growing number of young people in our population, mean that more dollars and more resources will be devoted to education. How much larger a proportion of our total national output this will require depends on the future rate of growth of the economy.

The advances of science and technology have also been primary factors in the larger proportion of our total resources invested in health and the dramatic improvements in the general level of health that have occurred in the last fifty, and even more in the last twenty-five, years.

Environmental sanitation began to assume significance in this

country in the 1860s and 1870s and is taking on renewed importance today as water and air pollution and radiation hazards mount. The beginning of effective control of communicable disease early in this century marked another stage in health care, and one that in this era of jet travel requires continuing attention on a world-wide scale.

Since 1940 we have greatly increased our total expenditures for medical research, particularly from Federal funds, and this is an area in which it appears that more funds will continue to be spent. Whatever medical discoveries lie ahead, however, it is probable that for some time to come personal medical care will be the most important factor in the further improvement of health. Two areas of particular concern are those of mental health and the medical care of older persons.

The level of our total national expenditures for health services is likely to be significantly influenced over the next decade by the way we resolve the problem of payment for care. Some method of spreading the risk and cost of heavy medical expenditures, for all groups in the population, becomes increasingly important. How this is accomplished will, in turn, affect the balance between the different kinds of preventive and treatment services that are provided.

In 1929, the first year for which we have such estimates, about 3.5 percent of the gross national product was going into hospital and other medical services, hospital construction, and medical research. About one seventh of the total was spent from public funds, primarily for care in state, local, and veterans' hospitals, and for general public health services. Today we are using almost 5 percent of our total output for health and medical services, and about one fourth of the total comes from public funds. The increase in the public share has resulted from a number of separate developments —greatly enlarged expenditures for public hospital care; newer programs, such as vendor payments for medical care under public assistance; substantial increases in maternal and child health services and medical research; and additional use of public funds for construction of private as well as public hospitals and other medical facilities are among the more important.

Since 1948, the first year Federal funds became available for this

purpose, hospital construction has just about kept up with population growth and obsolesence of older facilities. We still have only 75 percent of the general hospital beds and only 53 percent of the mental hospital beds that the state hospital planning authorities estimate are needed. To make up these deficiencies, to expand facilities for research and for outpatient care, and to assure that adequate medical services actually reach the entire population, we may well have to increase the proportion of our total resources used for health services. The investment, if we decide to make it, would yield important returns.

If education and good health are necessary conditions of economic development, social security programs are a necessary outgrowth of industrialization. Increasingly as technology becomes more complex and work more specialized, the individual is separated from the production of the necessities he and his family must have for everyday life. At the same time, the goods and services that a dynamic economy produces in ever greater abundance and diversity must be widely distributed and consumed if the process of production is to go on. With the organization of our entire economy dependent on a continuing flow of money incomes, some institutional mechanism for assuring a regular source of income for the nonearning groups is essential.

There are certain periods of nonearning for which the need to plan is evident. These are what we usually refer to as the common risks—sickness and disability, unemployment, death of the breadwinner, old age, or retirement after a specified age. For persons in such circumstances social insurance has proved a successful income distribution mechanism and one particularly appropriate to a dynamic economy. Benefits related—though not in strict proportion—to the individual's past earnings can reflect individual differences in living standards without direct inquiry into personal circumstances and thus reinforce incentives to individual effort and encourage individual savings. The contributory basis of financing not only provides a stable source of funds but supports the concept of benefits paid without regard to other income. A broadly based social insurance program encourages the mobility of labor and the flexible adjustment to technological change that our kind of econ-

omy requires. And payments which to the individual family mean an assured source of income to buy food and shelter and other necessities are for the economy as a whole an important supporting and stabilizing factor.

Historically, the first type of social insurance to be adopted in almost every country has been workmen's compensation—in other words, insurance against the risks most clearly associated with an industrial economy. In this country workmen's compensation laws were adopted in a number of states before the First World War. We also had, prior to 1935, a long-established veterans' pension program and retirement plans for some government employees as well as private pension plans for a few favored groups of workers.

The Social Security Act laid the foundation for a major new development which has not yet reached its full potential. Social insurance benefits payments now represent more than 3 percent of our gross national product, compared with less than one half percent in 1929. They will continue to grow for some time to come, even without further changes in the existing programs, as a still larger proportion of the aged population is able to qualify for Old Age, Survivors, and Disability Insurance (OASDI).

In addition to the clearly defined circumstances in which a continuation of money income is necessary in a developed economy, there must be some way of meeting individual need whatever its cause. As the general level of well-being rises, a society which stresses human values will find it intolerable that anyone should fall below a minimum level. Nor can a society as interdependent as ours afford sizable islands of poverty or the continuing problems of poor health, limited education, and maladjustment which they create.

The Social Security Act marked a turning point in this country in attitudes and programs designed to meet individual need. The substitution of cash payments for relief in kind moved dependent families into the money economy and the general consumer market. The use of Federal grants-in-aid to help finance assistance—thus drawing on the superior financial resources of the National Government while retaining state and local administration—was another innovation of far-reaching importance.

In 1929 we were using a little over one half of one percent of our national output for public aid and for institutional care for dependent groups (the expenditures for cash assistance and other aid cannot be separated). At the depth of the depression of the 1930s we were spending more than 4 percent of a shrunken national output for public aid. Since 1950 the proportion of our rising total output going for public assistance has remained a steady eight tenths of one percent, reflecting the net effect of the growth of social insurance on the one hand and, on the other, higher standards of public assistance in many states, additional Federal matching funds, and population and other changes.

Up to the present, the public assistance program in the United States has in large measure filled in for social insurance—taking care of old persons, the disabled, and orphaned families that have not had an opportunity to qualify for insurance. With the passage of time, this role for public assistance is diminishing. Its role for the future must be that of supplementing insurance benefits that do not meet the determined needs of the individual and, more basically, that of meeting any needs whatever their cause and wherever they are found. We are a long way from this latter goal.

As a society we have accepted the idea of a socially provided continuing source of money income more completely with respect to aged persons than with respect to any other nonearning group. For persons aged sixty-five and over OASDI is now by far the most frequent source of income. At the end of 1958 three fifths of all aged persons were drawing such benefits, and another tenth were eligible to draw them when they or their husbands retired. Most of the persons receiving private pensions are also getting social insurance. Public assistance provided the major support for another 12 percent of the aged population. Only 10 percent had no income—from either employment or one of the public income-maintenance programs. Ten years earlier, at least 30 percent of the aged had no income from these identifiable sources. It is clear that we have come a long way in terms of the number of aged persons who can rely on a regular payment to provide them some income security.

Opinions would differ as to how much satisfaction we should take in the size of the payments. The average monthly benefit paid

to a retired worker under OASDI in March of 1959 was $72. For an aged couple the average was about $120 a month, but for an aged widow only $56. Many beneficiaries have other income. A recent survey showed, however, that in 1957 one fourth of the beneficiaries had practically no money income other than their social security benefits. Home ownership was the most important asset and form of saving for most of the beneficiaries. The cost of medical care looms as one of their major problems.

By contrast, of the slightly more than three million persons under age 65 with long-term total disabilities, no more than 40 or possibly 45 percent are getting some income from one of the public income-maintenance programs—including OASDI, the retirement programs for railroad and government employees, the veterans' program, workmen's compensation, and public assistance.

There is a natural reluctance on the part of the general public to provide an alternative to earnings for persons who are not visibly severely disabled. Moreover, some professional groups fear that too generous support may discourage efforts that might lead to rehabilitation. New knowledge with regard to human behavior and human motivation is bringing into question the traditional view that a disposition to avoid work is normal with most men. We may find that many, if not most, individuals are better able to concentrate on learning to overcome their disabilities when there is an assured source of income for the family during the period of rehabilitation and readjustment. In any event, we must recognize that only limited rehabilitation at best is possible for some considerable proportion of the disabled.

Somewhat similar ambiguities of attitude have affected unemployment insurance and reinforced other factors that have led to the now generally recognized inadequacies of this program. In most states, unemployment insurance benefit amounts are, in theory, intended to replace about 50 percent of the worker's normal earnings. Because maximum dollar amounts fixed in the statutes have not been increased as much as wages have risen in recent years, however, most workers now get substantially less than this. During the twelve months ending September, 1958, three out of ten of the persons who had been drawing unemployment benefits exhausted their

benefit rights before they were reemployed. Unemployment compensation has replaced only about 20 to 25 percent of the wage loss resulting from increased unemployment in each of the three postwar recessions. The President has urged the states to lengthen the duration of benefit rights, as well as to raise the benefit levels. The general feeling in this country, however, is that benefits should not continue over too long a period. We have not faced up to the question of what provision should be made for workers who cannot find employment at the end of twenty-six or thirty-nine weeks. This question may become more pressing in the next few years if, as many economists suspect, we are entering on a period when the primary cause of unemployment will be not so much cyclical ups and downs of business activity as rapidly changing technology and the consequent displacement of older workers.

With nine out of ten children now protected under OASDI, and with improved health and mortality rates, orphanhood has become a diminishing social problem to an extent that would have been almost inconceivable in 1910. For children in families where the father is employable but unable to find work, and for children in families separated by divorce or desertion, we have provided a much less dependable basis of support. There are still twenty-three states in which public assistance is unavailable to employable persons in some or all communities. Even if we are willing to let the adults shift, we need to remind ourselves that the children in such families make up a large part of the human resources whose health and education and general outlook will greatly affect our future.

In evaluating the public assistance programs, one is torn between emphasis on the advances we have made since the 1930s in recognizing a responsibility to provide needy persons with at least minimum income and medical care, and emphasis on the need that is still unmet. One does not have to have new family budget studies—useful and desirable as they would be—to recognize unmet need in Aid to Dependent Children payments that nationally average $29 a month per recipient, or maximums on such assistance that in twenty-nine states reduce payments below the amount that the state public assistance agency had determined to be necessary for basic needs. In recent months more than one third of all public

assistance recipients throughout the nation and 20 percent of the total population of one state have had to rely for an unknown portion of their diet on the few commodities now distributed as surplus food.

There has been considerable emphasis on personal inadequacies as a major cause of the poverty remaining in this country, and no doubt these are factors in many of the families with the most difficult problems. Lack of income itself may, however, be one of the most devastating causes of family stress and of inadequate functioning on the part of the individual. Increasingly, the need for assistance will probably be concentrated among families who have, or could have, some earnings but not enough for an acceptable minimum level of living. To provide needed support while encouraging the maximum independence possible for such families may require all our skill and social inventiveness.

There is today a heavy concentration of poverty among minority groups. Here it is not welfare spending as such that is needed, but a lessening of discrimination in employment, in housing, in education, and in other areas of social life. Other pockets of poverty are found among groups such as migratory agricultural workers, or families in chronically depressed areas, who have remained outside the institutional changes that have raised the levels of living of the majority of the population. The long-term solution for them may be a combination of further technological change, special training and retraining programs, and special efforts to bring health and educational services particularly to the children in such families. Until these measures can take hold, however, there remains an obligation to meet existing needs more adequately than they are being met in many parts of the country.

The rapidity of social change and the pressures of urban living are intensifying a variety of social problems which have existed for a long time. The rise of juvenile delinquency in all countries of the world is a phenomenon the more disturbing because neither the causes nor solutions to the problem are fully understood. The rise in the number of illegitimate births, to cite another example, and particularly the increasing proportion of such births among teenagers, has intensified the need for services of several kinds.

At the same time, the growing professional skills of the social worker are making possible new types of specialized services as well as more effective development of older types. Casework services to children in their own families, help with family conflicts, encouragement and help in finding and using community resources—these may be needed by only a small proportion of the population, but they can be of strategic value in preventing breakdown and fostering independence.

The field of rehabilitation also has taken on new dimensions with the development of medical and restorative techniques, greater understanding of mental illness, and improved casework skills. We are still falling far short, however, of meeting even the most evident needs in this area.

There is a growing demand, also, for community services of another kind. Almost one third of all mothers with children under age eighteen in this country are now working in paid employment. A recent nation-wide survey conducted by the Bureau of the Census for the Children's Bureau found nearly four hundred thousand children under twelve who had to care for themselves while their mothers worked; over a million children were looked after by nonrelatives. Like many other community services, organized and supervised day-care arrangements for children are needed by families of all income groups. They would be of greatest benefit to those women who must work to support their children.

When families were large and neighbors closer to one another's problems, someone could usually be found to assist the household temporarily when a mother was ill or to provide the special help needed to keep an older person out of an institution as long as possible. There is still much informal aid of this kind in our society. But in the big city, and even in the big suburb, homemaker services must be organized if they are to be available to those families who need them most. There are only 143 agencies, most of them voluntary, in the entire United States that now provide such services. There is general agreement on the need for some assumption of public responsibility in this field.

The trend away from public support of institutional care that came as a reaction to the abuses of the almshouse is gradually giving

way to a recognition that with the prolongation of life there will be increasing numbers of older persons and chronically ill for whom some form of institutional care is desirable and necessary. The development of a sufficient number of adequately supervised nursing homes and boarding homes or other types of institutions has also become a major need in most communities of any size.

The public assistance program is providing an ever larger volume of casework and rehabilitative services for needy persons. Public expenditures for institutional care, for vocational rehabilitation, and for social services other than those provided in connection with public assistance are now taking perhaps one tenth of one percent of our national output, about the same proportion as in 1935. Institutional care has become relatively less important; provision of services to persons in their own homes, a larger part of the total. (For perspective let me point out that one tenth of one percent of our gross national product is not a small sum of money. It is now approaching $500 million.) In 1955 private agency expenditures for family and other welfare services were a little more than three times as large as the corresponding public expenditures, excluding those under public assistance.

As all social workers are acutely aware, further expansion of many of these services is being held back by the shortage of trained personnel. In part, such shortages reflect earlier low levels of support for the service. Even with scholarship and other training aids, they will take time to overcome. An even more difficult problem may be that of finding an organizational base that makes possible a rational relation of specialized services to one another and to the families served.

If they are to fulfill their functions adequately, the institutions of social welfare must have a dynamism at least as great as that of the economy and society in which they operate.

I have referred to some of the social changes of the past which have molded our existing welfare services and programs. Changes that one can already see ahead and others that we cannot foresee will have a similar impact.

Our population is growing and growing fastest in the younger and older age groups. By 1970 we shall probably have at least 37 mil-

lion more persons in the total population. There will be 16 million more children under eighteen, an increase of 25 percent, and over 4 million more persons aged sixty-five and over, an increase of 27 percent. Those in the working ages will increase about 17 percent. Even with automation and higher productivity, we will probably see a still larger proportion of women working outside the home.

Thus we shall clearly need to spend more on all types of social welfare programs simply to maintain today's per capita level of spending. But with an increasing proportion of children and old persons, and with continuing geographical shifts in population and the need for new facilities and organization of services which such shifts involve, a higher per capita level of spending will very likely be necessary to maintain the same level of service.

There is another reason why we shall need to spend more dollars for the same level of service. Barring an all-out nuclear war, we can safely assume that the growth of productivity which has characterized our economy in the past will continue and probably at an accelerated rate. The additional output per capita could be distributed in part through lower prices for some goods and services. It will probably be distributed in large part through higher earnings—with or without price inflation. Higher earnings would be reflected in the salaries of teachers, doctors, social workers, and all the other professional and nonprofessional groups engaged in the provision of social services.

A considerable part of the increase in total insurance benefits and in assistance payments since 1940 has resulted from changes made to bring benefit levels and standards of need in line with rising prices. The adjustments have not always been made promptly; nevertheless, we have recognized a general obligation to maintain the real value—in terms of purchasing power—of the long-term insurance benefits. Presumably, we will continue to do so.

But if our national output continues to grow, the incomes of the working population will go up even though the price level remains stable. One of the important questions of social policy for the future is the extent to which the groups whose income is largely from social insurance or public assistance should share in rising prosperity. To the extent we wish them to do so we must expect to make

continuing changes in the level of insurance benefits and in the minimum level of need that is met through public assistance.

Obviously, if we are to spend more for social welfare, we will have to devise ways of financing those expenditures.

A part, but in all probability a limited part, of the increased expenditures for community services such as day care or homemaker services, or even certain casework services, may come from direct payments by the consumer or client. Those most in need of such services will not be able to pay in full, and the question therefore becomes one of how much can be done through voluntary contributions and to what extent it will be necessary to draw on public funds if such services are to be developed.

One of the strengths of social insurance has proved to be the contributory basis of the system. Workers have been willing to put aside some of their earnings to purchase income security—on the installment plan, if you will. Indeed, if a referendum were taken, the majority might prove more than willing to pay larger contributions in order to get more protection.

It is more difficult to raise revenues through general taxes. If as a people we want more public services, however, we must be willing to buy them through increased taxes at some level of government. Increased tax revenues need not necessarily mean higher tax rates, quite aside from any reforms that might be made in the tax structure. Tax yields from the personal income tax increase considerably faster than aggregate personal incomes when income is rising and decrease faster when it is falling. The yield of sales and corporate profit taxes changes at about the same rate as aggregate income.

Several years ago the Twentieth Century Fund published a detailed and elaborate study of *America's Needs and Resources*. The study not only traced the long-term growth in the national output, it also attempted to estimate unmet needs and the additional expansion in output necessary to meet them. In general, the method was to establish for each category of consumption a minimum standard—the Department of Agriculture low-cost diet, for instance—and to estimate the expenditures necessary to bring every-

one below that standard up to it, while leaving those above it with unchanged income and consumption.

In 1950, the study indicated, total personal consumption expenditures would have had to be about $12 billion, or 6 percent higher than they actually were, to assure a minimum standard of living for everyone. An increase of only one percent in total expenditures for food would have sufficed, but a 50 percent increase in personal expenditures for medical care was called for. To meet specified criteria as to minimum expenditures per school child, number of hospital beds per capita, broader coverage and higher benefit levels in social insurance, etc., it was estimated that government expenditures for all purposes other than national defense should have been $20 billion, or 36 percent more than they actually were. Projecting to 1960, the Twentieth Century Fund survey saw needed expenditures as still exceeding probable expenditures by 4 percent for personal consumption and by 20 percent for nondefense government programs. A total output of goods and services only 7 percent larger than the estimated national output for 1960 could cover these unmet needs. In 1950 a 17 percent expansion in gross national product would have been necessary to bridge the gap.

The dollar figures and the population figures in this study are already out of date. A new study of needs and resources would present many differences in detail. It would almost surely, however, reinforce two major conclusions of this survey: (1), the progressive closing of the gap between our actual production and the amount needed to provide a decent minimum living for everyone and much more than that for the great majority of the population; and (2), the concentration of unmet needs in those services and programs that are provided from public funds and through the activities of government.

There have been several recent studies of the possible trend of events during the 1960s that suggest some of the alternatives for social welfare in the next decade. Such economic projections are one of the important new tools that economists have forged in recent years. By carrying forward past trends in relation to foresee-

able and probable or desirable developments, they can give us some idea of the boundaries within which we can move.

The Committee for Economic Development has released a study on *Trends in Public Expenditures in the Next Decade* prepared by Professor Eckstein of Harvard. This study assumes that our total national output will continue to increase at the long-term average rate of 3 percent a year. Several sets of estimates of government spending are presented. The medium estimate assumes no major change in present attitudes or generally accepted goals. Within this frame, however, it allows for some increase in social insurance expenditures—balanced by increased contributions—a fairly substantial increase in expenditures for education, and moderate increases for medical research, pollution control, public housing, and urban renewal.

On these assumptions total government expenditures would take about the same proportion of the gross national product in 1968 as they did in 1958. With present tax rates, and the present division of responsibilities among the Federal, state, and local governments, Federal revenue would rise faster than expenditures, resulting in a balanced Federal budget by 1961 and a Federal surplus of over $11 billion by 1968. State and local revenues, on the other hand, would rise less rapidly than state and local expenditures, both because of the increased spending for education that is assumed and because of the fact that state and local revenues are less responsive than Federal revenues to changes in aggregate national income. As a result, all state and local governments combined would be running a deficit of about $3.4 billion by the mid-sixties, with the seriousness of the fiscal problem varying considerably—as it does today—from one area and region to another. The study points out that given these long-run pressures, several alternative developments could occur. State and local tax rates could be raised or new taxes imposed, functions could be transferred to the Federal level, new grant-in-aid or tax-sharing devices might be developed, or state and local services could be allowed to deteriorate.

The Rockefeller Fund Report of 1958 on the *Economic and Social Aspects of the United States Economy* approaches the problem from a somewhat different point of view. Its first concern is

with what we should be spending to meet the needs of a dynamic society. It sees those needs as including at least moderate, and, for its "desirable" projections, considerable, increases in public expenditures for social welfare programs. The report also projects a very substantial increase in defense expenditures, based on another Rockefeller Fund study. An attempt is then made to estimate how large an increase in national output would be necessary to support such expenditures.

The report concludes that if total output increased by 3 percent a year, government (at all levels) would need to take a slightly larger proportion of the total than at present to cover even the projected low-level increases in public programs. A 5 percent annual rate of growth would be necessary to provide for the desirable level of government expenditures and allow for slightly increased rate of growth in per capita consumption of food, clothing, and other consumer goods.

A 5 percent rate of growth is well within the bounds of possibility. Projections to 1970 which have been released by the National Planning Association use as the most probable figure an average rate of 4.2 percent. Economists differ as to how high a rate of growth we can sustain without some inflation—which every economist agrees is an evil, though many would say a lesser evil than stagnation and large-scale unemployment.

Whatever the future growth of our productive capacity, we shall not escape the problem of choice as to its use. The choices are of many kinds and will be made through many different channels. There are the overriding decisions which determine our relations with the rest of the world. There are the local decisions which determine the character of the communities in which we live. Many of the choices will be made around separate programs.

The development of social insurance has brought into the realm of public policy the question of the share of the current product which should go directly to the aged, the disabled, the unemployed, or survivor families. The answers we give to this question will affect the amounts we spend for assistance and for other welfare services. Rising levels of living for most families give greater urgency to the problem of a minimum level of income support for everyone.

The new degree of public interest in education which has developed in the last few years is already reflecting itself in a variety of actions in local communities, and at the state and Federal levels. The rising demand for medical care is also working in a number of different directions. In some respects the most difficult choices to implement are those which require new types of community organization and community planning. Some of the potential choices we might make will remain hidden until research and new knowledge bring them to light.

One of the most important tasks for those of us who are concerned with social welfare may be that of clarifying, for ourselves and for others, the values and the processes involved in the choice of social welfare goals.

The Future of Public Assistance

by ELLEN WINSTON

THROUGH THE BROAD PROGRAMS of public assistance the Federal Government shares with the states in the financing necessary to help take care of the needy aged, needy dependent children, the needy blind, and the needy permanently and totally disabled. The first three of the four programs were inaugurated through the enactment of the Social Security Act in 1935. That Act has been amended many times, and quite substantially in both 1956 and 1958. These amendments have brought the Act increasingly into conformity with broadening concepts of the role of the Federal Government in the public welfare field and of society's broad responsibilities for the well-being of individuals and families. Most encouraging were the 1956 amendments which recognized the tremendous role of public welfare in providing protective, preventive, and rehabilitative services. In 1958, among other gains, the long-sought matching on the average and the first steps toward a variable grant program were achieved.

Although administrative structures differ significantly according to whether the public assistance programs are state administered or are locally administered under state supervision, the fact that the programs are operated under the same Federal legislation and within detailed Federal policy statements means that for general purposes divergences in administrative pattern may be disregarded. While the focus of this discussion is on public assistance programs and their foreseeable future, we should first recognize the major contribution which has already been made during better than twenty years through these large and essential social welfare programs. Despite what remains to be done to strengthen the legislative base, the public assistance programs have moved forward stead-

ily toward more useful and flexible services for that large group of individuals and families in our society who remain so little touched by economic progress. Change has been in the direction of provision against more of the hazards of life in these United States, through provision for an expanded albeit still inadequate medical care program and the major new program of the last decade, aid to the permanently and totally disabled. The public assistance programs have been directed toward increasingly higher standards in the public social services themselves, and these in turn have had an effect upon all social welfare services. No longer are we concerned only with economic security, but more and more with the welfare of all children, a strengthened family life, and expanding programs for the aged. That adequate financial assistance and adequate social services should go hand in hand is clearly and simply stated in the pamphlet "More than Bread," issued by the Bureau of Public Assistance.[1]

At the outset we should recognize that as a nation we are more willing to legislate than to implement, and we are often loath to legislate in the social welfare field. We have only to look at the public assistance titles in terms of the emphasis on services, the commitments to training and research, to realize that our legislative base has outdistanced our ability truly to carry out the potentialities of these programs. We must also recognize major gaps in what we have legislated to date and continue to hope that succeeding sessions of the Congress will recognize such areas specifically. Side by side with gaps in social legislation are those in providing the kinds of services that are already possible under existing law.

It would be foolish to pretend that we do not have problems galore, that we are not now and will not always find ourselves dealing with controversial questions. We live in a society that feels considerable repugnance toward accepting the fact that there can still be people in need. Many persons refuse to recognize the hard core of continuing destitution. The programs themselves, the elaborate and varying formulas under which the grants are made, the complexities of administration, are so difficult that only by special

[1] Helen C. Manning, *More than Bread* (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Social Security Administration, 1958).

study can the legislator or the board member, or far less likely the average citizen, have any real understanding of the details and how the programs actually operate. With changes in the public assistance case loads, partly due to broad changes in our society and partly to the growing effects of Old-Age and Survivors and Disability Insurance, the types of cases that make up large segments of the public assistance case load are those about which the public, particularly the economically successful and socially secure public, becomes highly moralistic.

To an exaggerated degree, moreover, the individual case can become a symbol for the entire program. It would be a sad day indeed if we measured the success of our public school system by the individual child who, apparently bright, fails to make his grade, or if we judged the skill of the surgeon solely by the patient who did not recover. Yet in our public assistance programs, whether the description of the case be true or untrue, there are certain situations in every state that get into the current folklore. Again, while we are not eager in our modern society to accept the mandate to become our brother's keeper, we become exceedingly concerned over how our brother spends his money when it happens to come from tax funds. We often expect the impossible and the improbable—superior judgment in handling money, the most skillful buying habits, and a pattern of needs and desires substantially different from those which the ordinary citizen displays in his everyday living. Thus we have many pressures to control how public assistance recipients spend their money.

As an overlay to these basic problems there is scarcely a public assistance program in the country that has adequate resources to do the job at a level commensurate with the knowledge we already have. Thus the public welfare administrator, whether at the state level or at the local level, is daily faced with responsibility for those persons who represent collectively the most seriously handicapped group of people in a given state or community, and struggles to make all too small resources do a reasonably adequate job, quantitatively and qualitatively.

What we greatly need today is a realistic appraisal of the public assistance programs as an integral and continuing part of the social

welfare structure of our society. We expect the continuation, and indeed have experienced a rapid expansion, of the public assistance programs. Wishful thinking on the part of some people has tended to blind us to actual developments over a period of years. We might as well stop talking about reductions in the total public assistance programs unless some very basic changes in our economy and in our income maintenance programs take place. Rather the Federal responsibility is a continuing one—involving more Federal dollars —to help states provide a decent level of living below which no one need fall. This crucial point calls today for strong, affirmative support by all social welfare groups.

If we can refrain from being apologists for the programs as they are, and look at them realistically, we have a strong foundation of tested experience and expanding services upon which to build increasingly more effective services. Purposely, this discussion is concerned with what seem to be realistic developments in the reasonably foreseeable future, not with our ultimate goals.[2] Let us look at the four programs individually.

Old Age Assistance.—Recent amendments have given us a better financed old age assistance program. Had the states kept pace with the developments in the Congress, we should have practically wiped out grinding poverty for older people by this time. As predicted, the number of recipients of old age assistance has been slowly going down as old age insurance has increasingly come into its own. But any program which is providing currently for so many people is a significant factor economically and socially. Therefore, it behooves us to take another look at the adequacy of the payments; what the program means as a supplement to other resources, including old age insurance; how we are going to develop that body of specialized social services so essential to meeting the varying needs of a larger population in the older age groups; the effect of the gradual aging of this group as a whole; and the growing volume of health problems.

In most states, specialized services to supplement, or in lieu of,

[2] For a brilliant exposition of such goals, see Wilbur J. Cohen, "Needed Changes in Social Welfare Programs and Objectives," *Social Service Review*, XXXIII (1959), 30–42.

public assistance grants are largely undeveloped. If we really determine that we shall meet the needs of our older citizenry who receive old age assistance, whether it be the main source of income or a supplement to other resources, we have tremendous opportunity for skilled social services of many types. Services in their own homes, group care facilities of varying size and service, day care centers, homemaker service, a realistic medical care program—all are essential elements of a truly constructive program for recipients of old age assistance and for other aged persons who seek public social services. No one expects any segment of this case load, which still numbers almost two and one half million persons, to become self-supporting, but much can be done to promote increased self-care. The files of any really good public assistance agency contain ample evidence of what skilled services can mean to maintaining or restoring both self-respect and self-care for our needy aged men and women.

Aid to the Needy Blind.—Aid to the needy blind continues to reflect a small but steady increase. Certainly, we are doing a better job of case finding. Moreover, the continued strengthening of our rehabilitative services for this group is associated with improvements in our financial assistance program. The number of persons involved is small in comparison with the number in other programs, and such aid is a matter of clearly recognizing continuing obligations, of concern over the implications of recipient rates that vary so widely from state to state, and of more adequate specialized services.

Aid to Dependent Children.—It is one of the tragedies of our times that the Aid to Dependent Childen (ADC) program, the great bulwark for underwriting the needs of children, should be so generally misunderstood and that the agencies administering it, and its most loyal supporters, so often are on the defensive. It is now our largest program in terms of numbers aided, though not in terms of expenditures. Irrespective of contributing factors, it is indeed encouraging to note the steady rise in the numbers of economically deprived children who are receiving some financial support, inadequate as it so often is. At least, it means that despite the critics, despite the problems, we are less and less willing for children

to suffer acute deprivation. Surely a program in which the number of child recipients has increased from 1,650,000 in January, 1955, to 2,200,000 in January, 1959, reflects substantial strength and real, though often grudging, support, a commitment on the part of the government to meet children's needs.

When the American Public Welfare Association made its study of *Future Citizens All* in 1952,[3] the positive aspects of ADC were overwhelmingly revealed. The school attendance record of these dependent children was good. Less than average rates of juvenile delinquency were found among them. The case turnover was substantial, emphasizing the fact that generally ADC tides families over periods of crisis rather that becoming a way of life. These positive results were found despite the fact that children have always been discriminated against in terms of the amount of financial assistance. Even today the average money payment for every other type of recipient is more than double the payment per child. The difficulty of obtaining minimum adequacy of support for children was clearly reflected in the 1958 amendments to the Social Security Act which provided for Federal participation in an average payment of $65 per month for the aged and disabled and of only $30 per month for needy children. We should view with great respect the mothers and relatives who have been able to do such a really decent job in taking care of children in such thousands upon thousands of cases with so little money, in seeing that minimum needs were met on all-too-tight budgets.

That the character of the ADC program has changed must be realistically evaluated. This is partly due to socioeconomic changes and partly to the fact that we have failed to broaden the program to include other needy children. We have always been willing to accept society's responsibility for children when the father is deceased. Fortunately, we have few of those children any more because of declining death rates and because of Old-Age and Survivors Insurance benefits. Hence, the families that the public calls "worthy" are sharply declining in our case load. Increasingly, the problem is one of desertion, an indication of the difficulties in se-

[3] Gordon W. Blackwell and Raymond F. Gould, *Future Citizens All* (Chicago: American Public Welfare Association, 1952).

curing jobs, of the mobility of our society, of the lessening of the strength of family relationships. While the public is annoyed with the behavior of parents who desert and fail to support their children, it is not willing as yet to give substantial help to our welfare departments through the courts and through the law enforcement officers in helping to locate those absconding parents or, if located, to see that they meet their obligations for the support of their children. We hope that greater use of the Uniform Reciprocal Enforcement of Support Act will provide a partial remedy.

We have found little public attention given to the children whose needs grow out of the fact that parents are in institutions because of mental or physical illness or in prison because of antisocial behavior. Rather we have the emphasis across the country on increasing recognition of the problem of births out of wedlock, a problem which is accentuated today because of its relationship to certain cultural groups. Certainly, we are not willing to write off the welfare of a significant number or proportion of our American youngsters. They are the victims of circumstance, and those of us who should be seeking opportunity to help them overcome their handicaps are all too often becoming apologists for the program set up to serve them, becoming so defensive that we try to explain away the negative aspects of ADC rather than center on the positive features.

One reason for this is that we know so little actually about the ADC program and the children whom it serves. It is becoming more and more unfortunate to pretend that publication of the number of children receiving help and of the average amount of help given by states, with occasional added statistics, is any reflection truly of the program and of what it means to the children of this land. Where are the real evaluations? In addition to *Future Citizens All* we have excellent studies which show what can be done through intensive work on the so-called "hard-core" families, or how by blanketing a given small area with a wealth of services we can dramatically improve the situation. All quite true and all important, but how about a positive unbiased evaluation of the 90 percent or so of the families receiving ADC who are getting along surprisingly well despite the meager grants and inadequate services which are

still characteristic of the program? We need research, and it is neither difficult research nor very expensive, which will focus on the positive contribution which ADC has made and continues to make. We need to put into proper perspective the problems which are and always will be part and parcel of this program. In how many states do we actually know what proportion of all the children born out of wedlock are receiving ADC help? Some research, very easily arrived at, will undoubtedly show that in most situations the great bulk of all children born out of wedlock are being taken care of other than through ADC. In how many states or localities do we really have an adequate program available so that we can remove a child from detrimental family settings when it is in his best interest? If we do not do so, we have only ourselves to blame if these families produce a second generation of illegitimate offspring.

What is being done by the other public services? Has public health accepted its responsibility with our up-to-date prenatal and postnatal clinics? Surely the first professional people to be aware of a birth out of wedlock will be the physician and the nurse. Here is an opportunity for constructive counseling, for proper referrals, for beginning to bring to bear early those community resources which help young people to conform more closely to the mores of our society.

The only agency which has an opportunity to make a significant impact upon all the children is the school, whether public or private. Births out of wedlock are associated in large part with our younger mothers, and only through the schools have we an opportunity to inculcate those lasting values which are so essential to the moral climate we desire as a nation. If there is a relationship between the incidence of births out of wedlock and the granting of aid to dependent children as frequently charged, it should have been seen long years ago. Rather the recent upsurge in births out of wedlock is due to much more complex factors. We ourselves in accepting the implications that there is such a relationship tend to distort the picture and to focus upon ADC when actually other positive factors are the significant ones. Only careful, fully objective studies which present the actual facts will clarify the issues.

Probably no state is more concerned over the problem of illegiti-

mate births than North Carolina. However, as a result of steady and continuous presentation in a positive manner of the facts in the situation, there is coming to be a much better understanding of what the problem is and upon whose shoulders the responsibilities rest.[4] Even those who are most concerned about the problem of unmarried parenthood can and will quote accurate figures and make public statements with regard to the breadth of community responsibility.

Do we know what is happening to the children in the ADC case load? What kind of adults do they become? How many people in our country today were at some time benefited through the ADC program? Every state has scores upon scores of young people who are good citizens, who pay their taxes, who support their families, who were aided, usually briefly, through ADC when crises struck the family. Have we tried to follow up these young people? Has there been any measure of their contribution to their communities and states? We have been derelict in counting the values of the program because we have been so overwhelmed by the problems.

Today, as perhaps never before, we are listing our manpower needs. We are concerned about the physical and scholastic inadequacies of our young people. Have we who are in the public welfare field accepted our responsibility for seeing that the potentials among the children receiving ADC help are recognized and promoted? We should be tremendously impressed by those dedicated public welfare workers who are constantly alert to the boys and girls in their all-too-large case loads who are bright, who should have opportunity, and for whom they see that there is opportunity. Across North Carolina there is continual concern that we help these boys and girls complete their high school education, that if they are even moderately bright and ambitious, there be opportunity for further training. Our Federation of Women's Clubs is a major organization. A year ago it established a quite adequate scholarship which can be renewed for the entire four years of college. The first award of this scholarship went to a young woman who had been aided for many years through the ADC program. This is not

[4] North Carolina Conference for Social Service, "The Problem of Births out of Wedlock—a Preliminary Report" (Raleigh, N.C., 1959).

unique. What is unfortunate is that too often we have written off the children and have not seen that they had adequate opportunity; nor have we given to the public any accounting of the strengths of the program and its positive contributions. The opportunities for constructive service are limited only by our own lack of resources and imagination and perhaps of confidence in the potentialities of the youngsters involved.

The president of the Carnegie Corporation of New York has succinctly stated the case, quite apart from the ADC program, with which we have so glaringly failed to deal:

> The fact that large numbers of American boys and girls fail to attain their full development must weigh heavily on our national conscience. And it is not simply a loss to the individual. At a time when the nation must make the most of its human resources, it is unthinkable that we should resign ourselves to this waste of potentialities.[5]

Implementation of the recommendation of the Advisory Council on Social Security to the Senate Committee on Finance a decade ago that "the Federal government's responsibiilty for aid to dependent children should be made comparable to the responsibility it has assumed for old-age assistance and aid to the blind" [6] is now ten years overdue. Hence we must devote our best thinking and our best efforts to how we can improve that program.

Aid to the Permanently and Totally Disabled.—Here we have a program which varies sharply from state to state—from the state that is willing to make the greatest possible use of this program as set up under Federal law to the state which has such strict legal requirements that the program cannot begin to meet its potentialities. Here too, the recipients are increasing in numbers and will continue to increase due to the limits in the disability insurance program. It appears imperative to point out again how great is the opportunity for constructive services, broadly rehabilitative in character, if we are willing to provide the essential resources. We are constantly redefining the handicaps which can be lessened or

[5] John W. Garner, "The Servant of All Our Purposes," reprinted from 1958 *Annual Report*, Carnegie Corporation of New York, p. 3.

[6] *Recommendations for Social Security Legislation*, 80th Congress, 2d Session, Senate Document No. 208 (Washington, D.C.: U.S. Government Printing Office, 1949), pp. 105 ff.

even removed through intensive services. But as is true of ADC, this program operates far short of its potentialities for helping people to help themselves.

General Assistance.—Comprehensive coverage of aid to needy people can be achieved either through an additional category of general assistance under the Federally aided programs or through abolition of all categories. Realistically, we are more likely to obtain a new category before we eliminate categories. Elimination of categories may, and should, come in time. A new category of general assistance is long overdue.

It is somewhat startling on careful appraisal to realize the limited support so far for general assistance. We know that without such a Federal grant-in-aid program we discriminate among needy people. We have been unwilling to recognize fully the tremendous hardships individuals and families face when their means of a livelihood vanishes, even temporarily. Despite all the statements about strengthening and preserving family life, the absence of a general assistance program comparable to the other grant-in-aid programs actually contributes to family breakdown. The breadwinner becomes ill temporarily. The ensuing deprivation of the family, even though he may be hospitalized at public expense, intensifies the family's problems and makes their return to self-sufficiency even more difficult. If we neglect the individual who is temporarily ill, we may contribute to his complete breakdown so that eventually the family qualifies for aid to the permanently and totally disabled.

Or take the case of the unemployed father ineligible, or no longer eligible, for unemployment compensation. If he receives any help, it is grudgingly given, and grossly inadequate in most states. But if he deserts his family, he makes his children eligible for ADC. Small wonder that desertion is today the most important reason for the need for ADC.

There are many people who are admittedly concerned over a general assistance program because they feel that the number of recipients and the costs can easily get out of hand. With the experience of twenty years behind us, surely the program can be defined with sufficient clarity so that it can be administered on a sound

and reasonable basis. The gaps in aid to needy persons should be filled without further delay, and the needy who would be covered should have the security of state-wide standards for the distribution of available funds, as contrasted with the present wide range in individual states. Moreover, those sixteen states which still fail to provide any appropriation for general assistance could be expected in most instances to set up a program promptly were Federal matching funds available. As crises develop in our economy from state to state due to technological changes or other reasons, whether in an industrial center, a region dependent on natural resources, or an agricultural area, the problems are accentuated by our failure to follow the recommendation made by the Advisory Council on Social Security in 1949 for Federal grants-in-aid for general assistance payments to needy persons not eligible under the existing public assistance programs.[7]

It seems appropriate to point out that the purposes of a general assistance program could be partially filled through extensions of ADC and APTD by broadening of the definitions to take care of the hazards of unemployment and of temporary disability. In other words, partial steps toward the goal of Federal participation in general assistance should not be overlooked as we work toward a truly comprehensive program.

No single aspect of the public assistance program has been more subject to broad study on the part of voluntary as well as public agencies in recent years than that of residence or settlement. With our mobile population, with the large percentage of the funds for public assistance that comes from Federal sources, it is an anomaly that states are still able to maintain high residence requirements.

Sufficient evidence has been accumulated by states that have done away with such limitations entirely, or have reduced the residence requirement to one year, to indicate that people do not move because of the expectation of public assistance. The only tangible result of residence requirements is to deny needy people the benefits of Federal programs established to help them in times of crisis and destitution. The deleterious effects of residence requirements have been graphically displayed in recent years in the plight of thou-

[7] *Ibid.*, pp. 108–12.

sands of migrant workers and their families. "In our society, mobility of population is essential. Individuals should be free to move where jobs are available and if, as a result of illness or other misfortune, they become needy, they should not be denied assistance because they have crossed state or county lines." [8]

To expect states, one by one, to take the necessary action to eliminate residence as an eligibility requirement is unrealistic. The only method that will result in prompt, remedial action is amending the public assistance titles of the Social Security Act. Not only have public and voluntary agencies taken clear positions on the issue, but also Secretary Flemming, of the Department of Health, Education, and Welfare, has publicly stated that residence requirements for public assistance should be eliminated.

As we look to the future, we know that public assistance will remain a large and signficant part of our total social welfare program.

The time is long overdue for recognizing that professional programs in the welfare field should be carried out by professionally equipped individuals, just as we expect professional health programs and professional education programs to be carried out by persons qualified in these specific fields. This is particularly important in public welfare where there is not only the demand for adequate administration and program planning and for skilled social services but also where interpretation to the public and leadership in helping the public to evaluate the programs and their role in our society is so essential. Public welfare, in which public assistance dominates both in money and in cases, must become a professional field within state and local government, comparable to other professional fields.

The Federal Government has long provided financial aid for training in many areas. Have we, the professional people in social welfare, been derelict in our emphases when today we still find no funds available for training in public assistance despite enabling legislation? Among the many areas of needed advance, none takes priority over the crucial need for a rapid increase in professionally qualified staff, a substantial proportion of whom are committed to a career service in the public agency. We cannot longer afford the

[8] *Ibid.*, p. 117.

costs inherent in such extensive use of untrained or inadequately trained staff.

The situation with regard to research is directly comparable. We spend millions of dollars annually without an adequate research program. No self-respecting business in the entire country would be as weak in terms of research or qualified staff as are we who carry responsibility for the administration of large public funds. We should be alert to the basic causes of the problems with which we deal so that protective and preventive services may become even more effective.

The frequent references to services require amplification if the public assistance programs are to be seen in their full perspective. Many changes have taken place over the past two decades. Wherever the public assistance programs are being carried out properly today, the actual determination of the money grant is only part of the process of helping the individual or family. How we approach the determination of eligibility, what we learn about the situation that has resulted in financial dependency, the extent to which the agency administering public assistance is geared to provide a wide variety of basic social services, what use is made of other community resources, both public and voluntary, are all germane to the central point of the money grant and its effectiveness in helping the recipient. Those persons who still think of the public assistance programs in terms of the early days do not realize that the gamut of services offered by the voluntary agencies can also be found in public agencies with the highest qualitative levels of service directly comparable, irrespective of auspices.

The tremendous volume with which the public agencies deal makes it imperative not only to strengthen broad service programs, but also to be realistic with regard to the changing public assistance case load. With the increase in so-called "hard-core" cases, we must build stronger programs of protective services; we must intensify our preventive services so that help is not merely palliative but is truly constructive. We must recognize that aiding the bedridden to become partly ambulatory, teaching the mother to budget more wisely, and a host of similar small steps are just as important in the long run as the more dramatic restorations to full self-support. Ac-

tually, the constant emphasis by public assistance agencies on rehabilitative services, broadly defined, is far too little known and too little appreciated. All these emphases contribute to the well-being of individuals and families and result in substantial savings, both human and economic. More and more a strong emphasis upon encouraging self-care, promoting self-support where feasible, and strengthening family life will become characteristic of all public assistance programs, not just of those in the forefront of public welfare today.

This, in turn, will mean more selective management of the case load. Workers with special skills must concentrate on the hard-core cases that can show progress to even a limited extent. More attention must be focused on the families, especially in ADC and to a lesser extent in the disability program, which can with intensive work be helped very quickly to attain or regain self-sufficiency. The amount of movement in that part of the case load which is not stabilized by old age or extreme disability is already substantial. It can and must be accelerated, with goals directly related to the extent of change which can realistically be anticipated through skilled casework, or even by professionally untrained staff under good supervision in an agency that is committed to a strong service program. Thus, with adequate grants reinforced by skilled services, we can in our well-to-do society, if we will, determine that poverty shall not perpetuate itself.[9]

There are many desired changes that are recognized by public welfare administrators and their staffs. They are generally incorporated in the statement on *Federal Legislative Objectives, 1959,* of the American Public Welfare Association and in *Goals of Public Social Policy,* by the National Association of Social Workers. It is encouraging that these objectives need modification from year to year as we make progress toward the goals and as new goals are accepted. It is also encouraging that these goals can be shared by large states and small, by the well-to-do states and those with the fewer resources. We need these agreed-upon goals to achieve better programs. All too often we have thought of public assistance as

[9] For a detailed statement on this thesis, see John Kenneth Galbraith, *The Affluent Society* (Boston: Houghton Mifflin Co., 1958), pp. 329–32.

money grants only and not as a basic social service program. Furthermore, public assistance must be supplemented by, and supplementary to, a broad program of public social services available to persons who have no need for financial assistance.

I cannot think of public assistance as an independent program but only as a large and integral part of a comprehensive public welfare program in the best sense of the term. When public assistance falls into proper perspective, it becomes associated with other social welfare programs designed to offer a comprehensive pattern of services to those persons in the community who need and seek the services offered—and in fact to those persons whom we must often seek out if we are to meet our full responsibilities.[10]

I have not talked about the facts of public assistance particularly. I do not think it necessary to review in detail specific legislative goals. They are on the record. Rather it seems to me that as we face the future in public assistance those of us who are directly associated with the program, or who actively support its objectives, need a reevaluation of public assistance as our largest social welfare program, as a program that must be evaluated positively and constructively, as a program that must be presented in terms of its strengths rather than defended in terms of its weaknesses. If we can slowly but surely move in these directions, there will be more adequate funds; there will be more effective services. We will see that the demonstrations occur, that the research is undertaken. The public assistance programs are here to stay. Why not accept that fact without equivocation and give the kind of leadership that the National Conference on Social Welfare and its associated groups are prepared to give in meeting the problems of the poverty-stricken through broadened public assistance programs, administered with sensitivity and vision, so designed as to wipe out extreme destitution in our day, and really to implement the potentialities for a good society for all?

[10] For an example, see Jack L. Roach, "Helping Families Who Don't Want Help," *Public Welfare*, XVII (1959), 61 ff.

Public Funds for Voluntary Agencies

by ARLIEN JOHNSON

THE USE OF PUBLIC FUNDS by voluntary agencies is only one aspect of public-voluntary relationships in a total program of community services. It is currently of great interest because the growth of the public social services has brought about new alignments of program and funds. The use of what is known as "purchase of care" of voluntary services by public authorities has raised questions that need consideration in the interests both of public and of voluntary agencies.[1]

The diversity and complexity of relationships between voluntary and public programs make generalizations difficult. Diversity is found in the volume and distribution of services from state to state; compare, for example, the resources to be found in Nevada and Massachusetts. Diversity applies also in another area, that of public policy in making use of voluntary services. Closely connected with this is the variation in the extent to which different services are used to supplement public programs; for example, state and/or local subsidies to voluntary children's agencies, especially institutions, and to hospitals are much more frequent than to recreation agencies or homes for the aged.

The problem is complex also. Data are lacking that make comparisons in expenditures possible from year to year; also there is great variation in practice from state to state because of tradition and leadership. In contrast are Pennsylvania, which began in 1751 to grant lump-sum subsidies to all types of eleemosynary institutions, and Massachusetts, which for almost a half-century has prohibited the granting of public funds to voluntary agencies. Be-

[1] The term "agencies" is used to designate both institutions and organizations which provide services in the community.

tween these states are others in which are found varying degrees of financial interdependence.

In the light of such diversity and complexity of practice, how can we find principles and policies to guide us? Obviously, much more accurate and comparable data are needed than I have been able to assemble here, if agreement is to be reached about sound public policy. The most that can be done is to indicate what seems to be a trend line that might offer some sense of direction. "Trend," according to William F. Ogburn, is a term applied originally to the direction a river takes; applied to social data it indicates the course of a "river" which flows in a general direction, with various curves and bends around obstacles. Most of the data to illustrate the direction the trend is moving will be taken from the field of child welfare. This is because a marked program shift from voluntary to public care programs has occurred in the past two decades; and also because, with the increasing child population, cooperative arrangements between public and voluntary agencies will continue to be essential. Moreover, more data based on research have been available to me about child care than for other programs. In addition to analyses made by the Department of Health, Education, and Welfare, I have had access to three doctoral dissertations, two of which are limited to studies of policy with respect to use of public funds by voluntary agencies in the field of child care.[2] If a trend can be traced in this area, we may be able to make some tentative generalizations which should be equally applicable to other programs.

The use of public funds by voluntary agencies has at least three aspects that affect consideration of policy. These are economic, social, and philosophical factors.

Stated simply, the economic factor in the relationship between public and voluntary agencies is their unequal resources. Tax funds for welfare purposes have increased markedly while volun-

[2] The dissertations are: William H. McCullough, "State Subsidies to Private Child-Care Organizations in Pennsylvania" (doctoral dissertation, School of Social Service Administration, University of Chicago, 1959); Ruth M. Werner, "Public Subsidies to Voluntary Child Care Agencies" (in process, School of Social Service Administration, University of Chicago); Samuel Mencher, "The Relationship of Voluntary and Statutory Welfare Services in England" (doctoral dissertation, New York School of Social Work, Columbia University, 1957).

tary contributions have remained relatively static in relation to population increase. The estimated total of voluntary contributions for religious and philanthropic purposes moved from 1.3 percent of the national product in 1930 to 1.5 percent in 1955.[3] Comparable figures for public expenditures are difficult to compute. A study of America's needs and resources by the Twentieth Century Fund reported that from 1930 to 1950 expenditures for public welfare rose from $1.8 billion to $15.4 billion, while private welfare spending rose from $1.3 billion to $4.5 billion. In other words, public expenditures increased almost eight times while private welfare expenditures increased three and one-half times.[4]

The point to be made is that tax funds for health and welfare programs are showing a real increase annually, while voluntary giving does not have equal capacity to raise real income much beyond the present level. Tied as the latter is to corporation gifts, fluctuations can be expected as business earnings move up and down the scale.

The social factors that affect public-voluntary relationships are reflected in program adjustments and changes. Familiar to us are the facts about population growth which will result increasingly in disproportionate numbers of children and the aged; about early marriages and the fact that women make up one third of the labor force; about health advances which have successfully checked such diseases as tuberculosis and poliomyelitis. These and other changes have been so rapid that the maladjustments created in individual and community life have required large-scale programs which only government is equipped to undertake and finance. The result is that many voluntary agencies are having to reconsider their objectives and programs in the light of public services taking over functions formerly thought to be unique to voluntary agencies.

[3] *Giving, USA, 1959* (New York: American Association of Fund-raising Counsel, Inc., 1959), p. 30. See also Thomas Karter, "Voluntary Agency Expenditures for Health and Welfare from Philanthropic Contributions, 1930–55," *Social Security Bulletin*, Vol. XXI, No. 1 (1958).

[4] Quoted by Hugh R. Jackson, President, Better Business Bureau of New York City, Inc., "Financing Social Welfare to Meet Today's Needs" (Presidential address at the Eleventh Annual Meeting of the National Social Welfare Assembly, December 12, 1956; mimeographed), p. 2.

A few examples will make clear the significance of social changes which have led to program changes. Congress took historic action in 1956 in amending the Social Security Act to strengthen insurance features and coverage to include the totally disabled; it added to the statements of purpose for the assistance programs that in addition to financial assistance to needy people, the purpose was also to furnish appropriate public welfare services so that assistance recipients might become independent, and that aid to dependent children might help maintain and strengthen family life. The 1958 amendments made further increases in insurance and assistance provisions, adding dependents' benefits for disabled insurance beneficiaries and removing the limitation to rural areas for child welfare services. In short, under the broadened scope of the social security program, public agencies now provide some of the casework services to families and children which had been regarded as the special province of voluntary agencies.

Adaptations of programs of voluntary agencies have led to relinquishment of cash assistance to needy persons except in emergency situations, and to development of service for middle-income families where problems are primarily interpersonal rather than economic. With this new clientele, the voluntary agencies have introduced fees for service. They have filled gaps in community programs in such areas as recreation and group work with the aged, maternity homes for unmarried women; and a few agencies have developed research and demonstration projects in specialized types of services. On the other hand, some voluntary agencies have supplemented rather than complemented the expanding public services by becoming paid agents for the public authority. When this happens, as it has in many places, the distinction between public services and voluntary agencies becomes clouded.

The third and last factor is the philosophy which underlies public and voluntary services. By "philosophy" is meant a system of fundamental beliefs or specific convictions which serve as a guide to conduct for the individual or for society. In the United States certain of these convictions relate to separation of Church and State, to freedom for voluntary group endeavor, to private business enterprise, and to the activity of government in fostering

collective enterprises.[5] New inventions, changing conditions, require solutions democratically arrived at; but such solutions are guided by values held by the greatest number of people. Confusion often exists while new adjustments are taking place; this seems to be true now when public and private agencies are faced with economic and social problems of great magnitude.

Are voluntary and governmental services motivated by the same philosophy? Granted that both share the objectives of strengthening family and community life through welfare programs, I believe that each has its special motivation and each has a function to perform in an interrelated, community-wide program.

Many years ago Linton Swift stated very well the basic philosophy of the voluntary agency:

> The truly private or voluntary agency has its roots in deep human impulses that will always exist in all their variety and vitality. . . . It is up to the private agencies to see that these impulses find free channels of expression.
>
> In that last phrase lies the future promise and the peculiar characteristics of truly *private* social work. If private or voluntary agencies are to make their distinctive contribution to a community program, they must be—or must become what they are not now in many communities—expressions of different minority groups of informed citizens, each interested in meeting a special human need through special types of service not yet accepted as a responsibility of the whole community.
>
> In other words, the private agency, as distinguished from the public, is or should be a "minority" agency.[6]

Religion has been the fountainhead of the altruistic impulse for many people. While different faiths have placed different values on charity, all churches have sought to nourish it. All have developed systems of institutions through which to express man's sympathy for man and his love of God. Thus sectarian welfare programs are differentiated from nonsectarian. Whereas the Protestant churches have generally encouraged the growth of the public services, the Catholic position has been that government should

[5] An example is development of atomic energy. Should it be entrusted to private business, or should the government control sources of production? A struggle for equilibrium goes on constantly in such matters.

[6] Linton B. Swift, *New Alignments between Public and Private Agencies* (New York: Family Welfare Association of America, 1934), p. 12.

intervene only when people through their family, church, and other voluntary associations are unable to provide welfare programs; furthermore, that when government must act it should make use of existing voluntary structures to the greatest possible extent.

Governmental welfare services, as I have pointed out elsewhere,[7] arise distinct and apart from sectarian and nonsectarian philanthropy at the point at which the needs of people exceed the resources available to such an extent that their hardships and suffering offend the sense of justice of a majority of the population. A program that rests upon a broad base of social acceptance ceases to be a charity. Rather than a beneficence, the government service becomes a right to which a person may lay claim. The economist Harold W. Guest comments on the growth of collective enterprise in these words:

> A list of proper functions of the state is not something that can be drawn up for all time to come with no possibility of change. . . . Instead the functions of government at any given time can be understood only against the background of the total situation and in reference to the basic factors in the development of those functions. New social groupings, new advances in science and technology, new products and new methods of producing and distributing them, the fall of ancient customs and traditions and the rise of new philosophies and concepts of social welfare—all these play their part in the total changing picture which includes changes in political structure and functions.[8]

Guest then points out that what constitutes "public purpose" depends not only upon time, place, and circumstances but also upon "the attitudes and preconceptions of the judges handing down the decisions," and upon the program being found compatible with the constitutional and statutory powers of the governmental unit and in conformity with the conception of public purpose accepted by the courts.[9] Among the services which have become so well accepted as functions of the state that we no longer question their support are education, postal service, building and maintenance of

[7] "The Respective Roles of Governmental and Voluntarily Supported Social Work," *Social Service Review*, XXII (1948), 300–301.

[8] Harold W. Guest, *Financial Aspects of Collectivist Developments* (Lawrence, Kans.: University of Kansas Press, 1943), p. 460.

[9] *Ibid.*, p. 461.

highways, control of communicable diseases, and so on. Public welfare programs have also been a responsibility of the state since the founding of our country; but the extent and objectives of these programs have changed remarkably even in the past quarter-century, and give promise of further development. We do not have a Welfare State in this country but we have an increasingly coherent plan of insurances, assistance, rehabilitation, and services of various kinds which are intended to raise the level of life for all the population and to protect people against the inevitable hazards of an industrial society.

In summary, then, these generalizations might be stated as main-channel trends:

1. Since public programs, once established, are seldom abandoned, it seems likely that they will continue to grow in both quantity and quality.

2. With voluntary giving apparently showing slight increase, new incentives for giving will have to be found if contributions are to rise much above the present level.

3. The voluntary agencies are making adjustments to meet the economic and social factors affecting social welfare developments. Some of them are finding new areas for experimentation, new clienteles; others are supplementing rather than complementing the rapidly growing public services. A hopeful sign is the interest in studies and examinations of the role of the voluntary agency. Research as a basis for planning is recognized.

Is it possible to trace a trend in the use of public funds by voluntary agencies? The problem is extremely complex and reliable data are limited, but a few facts may serve as guide lines.

A study in 1929 [10] revealed that subsidies [11] given by state and /or local appropriating bodies took one of three major forms: (1) lump-sum grants to agencies named in the appropriations; (2) prescribed per capita grants to certain classes of institutions or

[10] Arlien Johnson, *Public Policy and Private Charity* (Chicago: University of Chicago Press, 1930), pp. 41–42.

[11] "Subsidy" is loosely used often to describe any grant of funds from one body to another. Here it is used to refer to a variety of grants, allowances, and gifts from a governmental body to a private corporation. In the narrower sense of the term it is never used to designate a grant made by one unit of government to another. Guest, *op. cit.*, p. 465.

agencies, most often those caring for children or the sick; and (3) appropriations to administrative authorities, usually the state central authority, for purchase of care in their discretion for certain classes of dependents, such as children. A study under way in 1959 of subsidies to child care organizations, conducted by Ruth M. Werner, offers some data, not comparable in all respects to the earlier study, but suggestive of developments during the past three decades.

States giving lump-sum subsidies for child welfare have declined from thirteen to eight; an interesting fact is that only five of the states now giving such grants did so in 1929. The Werner study shows a marked increase in the practice which was only emerging in 1929: purchase of care by the administrative authority, state or local. In twenty-eight states, payments for child care are made only when the public administrative agency accepts responsibility for care and makes a plan with the voluntary agency. An additional nineteen states make some kind of payments on a per capita basis.

All studies of lump-sum subsidies have shown that, unless they are granted for an emergency and then discontinued, subsidies are poor public policy. Around the turn of the century serious abuse of public appropriations to private institutions resulted in scandals which led many states to adopt constitutional prohibitions against grants of funds to voluntary agencies. In 1929 twenty-six states had such limitations, with eleven of them specifically forbidding grants to sectarian or religious associations. New York, which today makes extensive use of voluntary agencies through local governmental authorities, had such serious problems with lump-sum subsidies that in 1894 the state constitution forbade appropriations to private undertakings except for the handicapped and juvenile delinquents; but empowered the legislature to permit local governments to make appropriations for voluntary agencies. Other states, similarly, have prohibited state appropriations but have encouraged local subsidies.

Pennsylvania is, of course, the outstanding example of the deleterious effects of the lump-sum subsidy system. A grant was first made to a children's institution in 1857. McCullough's study reveals that in 1957, there were 29 children's organizations, most of

them institutions, among the 242 hospitals, charitable and educational institutions for which the legislature made a biennial appropriation of $60 million. These children's organizations received about $363,000 although an additional forty agencies and institutions were potentially eligible for aid. One reason for this unequal treatment is that the legislature still responds to individual appeals and selects recipients pretty much on the basis of who received a subsidy in the preceding year. Budgeting procedures in 1957 were much the same as they were in 1857. The Appropriation Committee has steadily resisted taking help from the Department of Welfare in setting standards and establishing budgeting procedures. In fact, central control by the Department of Welfare is weak because it has power only to recommend, while authority to enforce is divided. The 1955 appropriation to the Department included funds which could be spent for reimbursement to the counties and to private agencies for "care, treatment and re-education of children and adults in private and public institutions and foster homes." [12] McCullough's conclusion is that the subsidy system continues to exist primarily from the momentum of historical precedent. It has seriously hampered the development of public child care programs and responsible supervision of voluntary programs. Werner found that Pennsylvania does not have a basic public program for children nor does it have a licensing law. It would seem that Pennsylvania represents one of the curves in the trend and that it should provide a warning to other states not to become entangled in lump-sum subsidies.

The Werner study, based on a 100 percent return from questionnaires to all states and territories, provides some information on purchase of care for dependent and neglected children. She found that only four states (Arkansas, Mississippi, Nebraska, and Nevada) were not using public funds to provide care for children placed with voluntary organizations. Thirty-one states reported that less than one fourth of their expenditures went to voluntary agencies and that the remainder was spent under public auspices. A significant finding concerned the problem of control when care was purchased. At one end of the scale were three states which paid for care

[12] McCullough, *op. cit.*, p. 35.

but did not have responsibility for arranging or evaluating the care received. At the other end of the scale were 59 percent of the states, which made payments only when the public authority accepted responsibility for care of the child and made a plan with the voluntary agency in advance. Her conclusion is:

> There seems to be a direct relationship between the existence of a basic public program with state support for the care of dependent and neglected children and payment for care only when responsibility for care is accepted by a public administrative agency and plan with voluntary agency arranged by this public agency.[13]

In other words, a strong public child care program means strong supervision of the kind of care that is purchased from the voluntary agency or institution.

Many problems arise, however, in connection with purchase of care. These include (1) traditional relationships between voluntary and public services in a locality; (2) determination of the basis for rates of payment and for amounts, whether to cover full cost or partial cost; and (3) what standards should be maintained when care is purchased and who should determine these standards.

Traditional relationships.—States with a history of lump-sum or per capita subsidies to certain types of institutions or agencies find it the most difficult to establish a new basis for work with voluntary agencies. This new basis is purchase of care. In the case of children, for example, this means individual determination of what the child needs—not what kind of agency has been recognized by the legislature as eligible for per capita reimbursement. Oregon and Illinois are examples of long-standing legislation for per capita payments to certain types of institutions.

New York is probably the outstanding example of the effects of tradition upon public-voluntary relationships. As pointed out earlier, the state in 1894 forbade state appropriations but made local subsidies permissible. At the present time the state reimburses local welfare departments 50 percent for payments to private child welfare agencies.[14] In New York City, 17,000 children

[13] Ruth M. Werner, "Preliminary Report on Data Secured from Questionnaires on Public Expenditures for Care of Dependent and Neglected Children by Voluntary Agencies" (University of Chicago: doctoral dissertation in process; mimeographed).

[14] Raymond W. Houston, Commissioner, New York State Department of Social

were receiving foster care at public expense; only 7 percent housed in public agency facilities, with remainder under care in 100 different voluntary agencies. Nearly fifteen hundred children were awaiting placement in foster care.[15] Such complete dependence upon voluntary services is not typical of most of the country. We might venture, then, to say that New York, like Pennsylvania, represents a curve in the trend.

Traditional relationships between public and voluntary services may also result in different practices within the same state. California is an example. The state has a constitutional prohibition against grants to voluntary agencies except those for children and the aged; but since 1879 the state has had provision for state aid to counties for "needy children," whether under care of public or voluntary agencies. In Los Angeles County, where a "boom-bust" economy has made public services a necessity, a well-developed program of foster boarding care has been provided. The County Counsel has ruled that the county may not purchase services from a nonprofit corporation if the county has "competent employees" under Civil Service who can provide them; therefore, only group care is purchased since the county does not operate institutions for children. The situation in San Francisco is very different. It has had a stable population growth and early developed a tradition of payment to voluntary organizations for services that are often conducted by public authorities. About 85 percent of the children under foster care are wards of the Juvenile Court, which is empowered to administer funds for aid to needy children; and heavy reliance is placed upon sectarian agencies (Catholic and Jewish) which have large programs. When San Francisco City and County finally adopted an ordinance in 1950 to permit the Public Welfare Department to provide a program for dependent children, the ordinance specifically stated that the Department "first must call upon an appropriate licensed private child placing agency engaged in

Welfare, "Where Is Social Casework Going—the Changing Roles of Public and Voluntary Agencies," reported in *Minutes*, January 28, 1955, Conference on Individualized Services, National Social Welfare Assembly, p. 8.

[15] "The Management of Public Foster Care Programs," National Biennial Round Table Conference, American Public Welfare Association, *Public Welfare*, XVI (1958), 72.

the finding of homes . . . and where, in an individual case a licensed child placing agency refuses or fails to render the services needed, said department may use other available resources . . . directly." [16] The San Francisco practice is not typical of California's program for dependent children in the fifty-seven counties of the state. It may be said also to represent a curve in the trend of public-voluntary relationships. It has been described, however, to illustrate how a well-entrenched subsidy system, even on a purchase-of-care basis, may deter expansion of the public program. This is in contrast to Los Angeles where a strong public program has caused the development of a policy limiting purchase of care unless the county lacks the service.

Rates of payment.—A troublesome problem has been determination of the rate of reimbursement which the voluntary agency should receive for care of public wards. Should the full cost of care be paid? If so, at what point should the public authority take over the service? If part of the cost only is paid, does this fact strengthen the voluntary agency's appeal to the public for contributions? A study in Great Britain by Samuel Mencher offers interesting, if not conclusive, evidence about the development of a public policy.

Between 1950 and 1954 local governments expended about one million pounds for the care of children in voluntary homes. With the growth of the Welfare State, voluntary contributions have declined. Mencher states the policy in these words:

> The authorities, when possible, adhere to the position that a voluntary society should make some contribution to the cost of service. Though the cost of care in voluntary children's homes is lower than in statutory homes, the Home Office and the local authorities have followed the principle that voluntary homes should not be completely compensated for the care of local authority children. The Home Office and the local authorities, apart from reasons of economy, believe that voluntary societies should make some contribution because the voluntary societies in their financial appeals to the general public have emphasized their responsibility for all children requiring care. . . . The Home Office has suggested to the local authorities a 25/75 ratio

[16] City and County of San Francisco, Ordinance 5924 (Series of 1939), passed by the Board of Supervisors, March 13, 1950; and letter from Mrs. Beryl Reinhardt, Chief Social Service Supervisor, Public Welfare Department, San Francisco City and County, dated May 12, 1959.

of voluntary to statutory contribution toward the cost of care of local authority children in voluntary homes.[17]

Furthermore, it has been the policy of local authorities to exclude consideration of capital costs when determining rates of payment. Another point of interest is that payments tend more nearly to meet the full cost of care when the service is not one for which the public authority has made provision; for example, when the program for the handicapped was begun, heavy reliance was placed upon voluntary agencies.

In the United States, it would seem that where voluntary organizations are providing a large share of the service, as in New York City and San Francisco, pressure is steadily toward payment for the full cost of care.[18] Research is needed to ascertain what the policy is generally over the country, and what formulas can be devised to measure actual costs.

Setting of standards.—While the precise authority of the state over voluntary organizations varies from state to state, the English common law on which our institutions rest regards charitable trusts as in the public interest. The state, therefore, has responsibility for guaranteeing that voluntary endeavors are conducted in the public interest, and gives encouragement to them through exemption from taxation, through permitting endowments to be held in perpetuity, and through liberal interpretation of a donor's intent.

When state central authorities began to be established after 1863, state institutions which had operated independently with their own boards of citizens, and voluntary agencies to which the central authorities began to extend visitation, complained bitterly about the encroachment of the state upon their affairs. Now, in 1959, all

[17] Samuel Mencher, "Financial Relationships between Voluntary and Statutory Bodies in the British Social Services," *Social Service Review*, XXXII (1958), 141–42.

[18] *Public Welfare, op. cit.*, p. 74. City and County of San Francisco, Ordinance No. 183-59 (File Number 284-58-2), states that the "actual cost" of direct care, excluding costs of administration, and the "actual cost of supervision" with certain maxima shall be paid. The Ordinance further provides: "The responsible city department may contract for the services provided herein and the actual average cost . . . shall be based on a determination to be made by the Controller of the City and County of San Francisco." Each private child-placing agency and institution is required "to keep adequate records for the determination of the costs of care, administration, and supervision."

states exercise control to some degree over locally administered public programs; the state programs, in turn, are subject to scrutiny by the Department of Health, Education, and Welfare if Federal funds are used. A study in 1929 revealed that state supervision of voluntary organizations had been set up by statute in forty-seven states and that such supervision ranged from visitation only to licensing. In short, a trend toward centralized control is a phenomenon not only of economic and political life in the United States but also of the social welfare field.

Where money goes, control follows, is an axiom of public administration. That a certain amount of supervision by government is now accepted seems evident, especially when payments are made for service rendered. But the establishment of such standards is regarded as a matter of collaboration. Sectarian agencies, while wishing to preserve autonomy on all matters concerning religious instruction and practice, would seem to agree in the main with the statement of the Protestant delegates to the 1957 National Conference on Policy and Strategy in Social Welfare:

> The government should have responsibility for determining minimum standards of care given by *all* voluntary health and welfare agencies and to issue licenses on the basis of compliance. . . . The government, because of its responsibilities to all persons within its jurisdiction, must set minimum standards; but the church should constantly be striving for standards which are above and beyond the minimum so set.[19]

While there is general agreement that the public authority should set standards, problems arise in their application. The standards set may be higher than those under which the voluntary agency is operating; under pressure, the voluntary agency improves staff, increases costs, and then demands a higher rate of payment. Or the public authority may insist upon a nonsectarian intake policy, and the sectarian agency then finds so major a change in its clientele that it loses its sectarian character.[20] Another problem for

[19] "Policy and Strategy in Social Welfare," pp. 42–43.

[20] Martha K. Selig, "Income from Public Sources, Implications for Programming and Jewish Communal Planning" (New York: Council of Jewish Federations and Welfare Funds, General Assembly, *Use of Public Funds by Jewish Agencies*, November 13–16, 1958), p. 21.

the voluntary agency is the attitude of federated fund-raising organizations which encourage agencies to accept public payments and reduce the federation financial contributions accordingly, leaving the agencies dependent upon public funds if they are to maintain their programs. Finally, there is the danger of a voluntary organization's becoming so completely the agent of the public authority, dependent to a great extent on payments for care which do not cover total cost, that it finds itself with a marginal service program and no money to improve it.

Mencher found that subsidies had become a necessity for many British voluntary organizations. With the falling off of voluntary support, the subsidy had become a mark of community approval. But, in general, subsidies had led voluntary effort into the activities for which statutory money was available and thus checked their development of new types of services. Under the controls set up, subsidies had often improved the standard of voluntary services, but agencies had not been free to expand the quality and quantity of services at their own discretion.[21]

Because of the shift in policy which permits recipients of public assistance to pay directly for their own care, such as medical expense or residence in a home for the aged, it is difficult to get comparative figures on changes in amounts of income that voluntary organizations now receive from public funds. The Division of Program Research of the Social Security Administration has made an analysis of public payments based on studies made by the Children's Bureau and the United Community Funds and Councils of America, Inc. The figures were from more than twenty urban areas and excluded four large cities, including New York. Findings indicate that:

> The flow of funds from public agencies to private agencies for health and welfare services can be viewed from two points of view, namely, from that of the public agencies making these payments or from that of the private agencies receiving these payments. . . . What may represent a small payment to a public agency, may represent an important source of income for a private agency or vice versa.[22]

[21] Mencher, "Financial Relationships . . . ," pp. 143–45.

[22] Prepared by Thomas Karter, *Research and Statistics Note*, No. 37-1958, November 6, 1958.

From the standpoint of the public agency, it appears that the proportion of public expenditures that took the form of public payments to voluntary agencies went from 5 percent in 1948 to 8 percent in 1955. The increase is explained primarily by legislative changes which made possible the utilization of voluntary services; for example, public assistance vendor payments for medical care, vocational rehabilitation, and the child welfare programs.

If we look at the payments from the standpoint of the voluntary agencies we find that the proportion of income received from public funds varied considerably among the fields of service. Public funds were most important to agencies offering so-called "social adjustment" services, particularly those serving children. In both 1938 and 1955 private children's agencies received nearly one fifth of their income from public funds. Private hospitals received more public funds than all other types of private agencies combined (58 percent of the total in 1938 and 72 percent in 1955); but because of the large budgets of such hospitals, the public funds represented only 4.4 percent of their total income in 1955.

With this background about form, problems, and volume of payments from public funds to voluntary agencies, it might be well to undertake a more definitive statement about the meaning of the term "subsidy." Almost thirty years ago I defined a subsidy as "any payment from the public treasury, whether state, county, or municipal, either in lump sum or on a per capita basis for services rendered, under an appropriation to a designated institution or class of institutions." [23] What was in 1929 beginning to be discernible as purchase of care in the discretion of the governmental authority from an appropriation entrusted to the welfare administrator seemed to me to afford a new relationship between public-voluntary agencies. I wrote hopefully that the practices which were emerging—purchase of care—"promise to relieve the public authorities of the hazards inherent in traditional, haphazard use of subsidies; but the success of new arrangements would depend upon the further development of the science of public administration." The evidence today indicates that the solution is not so simple as this. I am inclined to agree with Miss Werner, who suggests that the material which she has collected from all of the states and ter-

[23] Johnson, *op. cit.*, p. 12.

ritories, and the more detailed study she has made of three selected states, has led her to believe that there is a continuum between subsidy and purchase of care.[24] I would like to propose a redefinition of "subsidy": any payment of a predetermined amount, made to a voluntary organization from public funds, in aid of, or in compensation for, care for a category of individuals served, where the payment is to be continued for a more or less indeterminate period of time and where the purpose is to provide care on an individual basis.

This statement would distinguish a subsidy from various governmental grants which are now available for time-limited and specific purposes related to program development. I refer to the Hill-Burton Hospital Survey and Construction Act, now extended until June 30, 1962; to the grants from the Institutes of Health for research and professional education of specialists; to Section 4 of the 1954 Amendments of the Vocational Rehabilitation Act which makes grants available to nonprofit organizations for research, demonstration projects, sheltered workshops, and so forth. Some grants of this kind require a certain proportion of matching funds from the agencies receiving them. But the important and distinguishing characteristic of all grants is that they are for a limited period of time and that they are for a specific purpose related to the development of programs. A subsidy, on the other hand, is usually ongoing, once established, and is intended to be used for a direct service to an individual or group of individuals.

Grants from voluntary funds represent the opposite side of the coin. A foundation has been described as usually "a nongovernmental, nonprofit organization having a principal fund, managed by trustees or directors, and established to maintain or aid social, educational, charitable, religious or other activities serving the common welfare." [25] There are now more than eight thousand organizations of foundation type with total assets estimated at about $10 billion. More than half of the total assets are held by approximately 150 foundations. The point to be stressed here is that the important expenditures are chiefly for national and international causes related to education, international understanding, research in medi-

[24] Letter from Ruth M. Werner, University of Chicago, dated April 8, 1959.
[25] *Giving USA*, pp. 38–39.

cine, the social sciences, the humanities, and public affairs. The recipient may be a voluntary or a public organization. The numerous small family foundations that have sprung up in recent years are likely to give support to local welfare, health, religious, and educational causes. But the foundation, like the government grant, is characterized by time-limited awards and specific program purposes rather than by services given directly to individuals.

A sociologist states that an hypothesis which is corroborated by repeated observations made by all qualified observers is called a "principle." It becomes a guide to action. The material which several national organizations generously made available, consisting of minutes, reports, proceedings of conferences, contained a number of common observations concerning public-voluntary relationships and the results of intermingling of funds. It is on the basis of these observations that I venture to offer three principles which may provide some guidance in the formulation of policy in this confused area:

1. *Each agency and each community should have a clear definition of the respective functions of voluntary and public services in that community.* In some localities voluntary agencies have long held the leadership in development of services; in other places, and increasingly everywhere in the last decade, the public agencies have given leadership and have shown great strength in pioneering new programs and services. But the differences between public and voluntary agencies with respect to financial resources and underlying philosophy should be considered as guides in the development of policies. If the voluntary agency exploits the fact that it can represent the point of view of a minority of citizens, it can move more quickly and flexibly than a large governmental agency whose mandate must come from the tax-paying public. The important point here is that each type of agency must know what it does represent, and that both recruit the support and understanding of citizens.[26] Each type of agency then needs to support the other in its unique place in the community.

[26] Charles Schottland, then Social Security Commissioner, reported that forty-six of the fifty-three states and territories had citizen boards or commissions, and that two thirds of the states had local welfare boards. "The Changing Role of Govern-

2. *Community planning councils, broadly based, must be the expediters in making short-term and long-term blueprints of community services, including division of responsibility between voluntary and public agencies.* Partnership in planning can lead to many different arrangements between public and voluntary organizations, providing functions and purpose are clearly understood. When there are serious gaps in existing programs, the voluntary agency may temporarily provide services. Interesting cooperative ventures may be undertaken, such as the nursing project in Philadelphia and the Youth Board in New York City. Are these short-term arrangements? Long-term? Those undertaking such cooperative plans need to understand the implications for program development. The community planning council, if oriented to total community problems and planning, should be the place to assemble material based on research which can guide citizens and professional people in forecasting the respective responsibilities of voluntary and public services. This will be successful if the public agencies are equal partners with the private in the support and control of the planning body. The American Public Welfare Association and other national organizations report a growing trend in this direction.

3. *Professional leadership has a major responsibility for helping in policy development.* More social workers in both public and voluntary agencies are needed who have historical perspective, insight into the dynamics of community life, and ability to apply the insights from their professional knowledge to the difficult problems of community relationships. National agencies have an opportunity to guide and stimulate studies, conferences, and raising of professional standards, locally as well as nationally. Administration of programs demands people who have philosophy as well as knowledge. Marshall Dimock, writing out of his rich experience as an administrator, describes executive work as "statesmanship"; he adds:

> The private part of the economy should always be on the defensive to justify its independence and its freedom from restraint, but by the

ment in Social Welfare," National Social Welfare Assembly, Spring Meeting, April 5, 1957.

same token those who administer the government ought to be chosen with consideration for whether they will do everything in their power to encourage this same independence and freedom from restraint.[27]

Without any doubt the social work administrator is the specialist whom the community has employed to help develop sound social policies. He must be equal to the task.

Research in this field is sorely needed. The complexity and diversity as well as the dynamic nature of relationships require that planning be based on fact and not opinion, however well informed opinion may be on some aspects of experience. Many questions need examination. One might ask when is a subsidy a subsidy a subsidy? When public funds pay for the cost of almost every child in the care of a voluntary agency, for example, at what point does the public welfare authority take over entirely? More than one observer has suggested that if purchase of care becomes so widespread that the voluntary agency is almost wholly dependent upon this source of support, then eventually the only private agencies for which there is justification will be those who represent a sectarian philosophy. What trends would a study of experience reveal and how might we develop conscious guides for division of responsibility? Dimock and others have analyzed the values in small or decentralized units and have maintained that size has more effect upon function and operation than does auspices, whether private or governmental. Does this suggest a line of inquiry which might help the voluntary agency maximize the advantages of its limits—especially if voluntary contributions are not likely to increase in proportion to population?

Other questions on which research might give guidance include the place of the courts in decision-making in public-private relationships, the effects of shift of control of subsidies from the legislature to administrative bodies, and the influence of subsidies upon standards of care. Finally, more definitive data are needed on the variations in practice in use of subsidies from one field of service to another. The material presented here is obviously fragmentary; it will have served its purpose if it helps to stimulate further inquiry and research.

[27] Marshall Dimock, *A Philosophy of Administration* (New York: Harper, 1958), p. 45.

Concepts of Income Adequacy

by HELEN H. LAMALE

PRESENT-DAY CONCEPTS OF INCOME ADEQUACY reflect the complex social and economic changes of the past two decades. Current opinions and definitions of an "adequate" income in a given situation often vary widely, but they generally subscribe to what may be called the "social" concept of income adequacy. In theory, at least, most people agree that an adequate income will provide not only for the physical necessities of life but also for the social and psychological needs of the individual or family. There is rather general recognition of the importance of evaluating the needs of the individual in his social and economic setting and in relation to the needs and resources of the economy.

The origin of this social concept of income adequacy lies in a growing awareness of the mutual dependence of the individual family and the social and economic structure of the community, the nation, and, in fact, the world. Recognizing the importance of the mutual dependence of family and society in economic matters is not a new idea. More than a century ago, Frederic LePlay made extensive studies to show that "fundamental prosperity is associated not only with a well-developed material standard of living but with a social system organized to preserve this standard of living." [1] Evidence that this idea of mutual dependence was molding present-day concepts of income adequacy can be found in much of the literature of the 1920s. One of the best statements of this idea was not made, as one might expect, in a discussion of social or economic theory but in an article on "modern selling." In 1924 a marketing expert said that "the health and prosperty of a community are de-

[1] For a discussion of the LePlay theories and studies see Carle C. Zimmerman, *Consumption and Standards of Living* (New York: D. Van Nostrand Co., 1936).

termined by the ability of the individual to take his part in the economic structure of his day."

Evidence of the current widespread acceptance of this concept can be found in recent statements from a variety of sources. President Eisenhower has stated that improvement of income maintenance programs "is desirable as a means of promoting general economic stability as well as personal welfare." [2] A committee on public assistance standards expressed it as follows:

> Citizens in our democratic society have a responsibility to develop the opportunities available to them and make their maximum contribution to themselves, their families and their communities. Primary emphasis, therefore, should be placed upon the development and maintenance of conditions under which workers and potential workers may secure for themselves and their dependents a standard of living essential to their own well-being and that of the community.[3]

A business economist, though skeptical of estimates of poverty, put it this way:

> All responsible citizens share the feeling that elimination of remaining poverty in America would not only bring greater happiness and opportunity to these people, but it would draw them into the stream of progress, enlarge markets for consumer goods, and promote expansion of the economy.[4]

The social concept of income adequacy is a relative concept, influenced by the prevailing levels of income and consumption and by current standards and manner of living. Acceptance of the general concept has little practical value unless the concept can be translated into reasonably valid measures of income adequacy for the many situations where such measures are needed. Historically, this has been accomplished by developing standard budgets which define the quantities of goods and services necessary to provide specified levels of living and by estimating the cost of these budgets at different times and in different places. With the social concept of income adequacy, budget standards are needed for self-support-

[2] "Economic Report of the President," transmitted to the Congress, January 20, 1958 (Washington, D.C.: U.S. Government Printing Office), p. 65.

[3] "Public Assistance Standards," a report by a Committee of the American Welfare Association, 1948 (mimeographed).

[4] " 'Poverty' in the Midst of Prosperity," Business and Economic Conditions, First National City Bank Monthly Letter, New York, November, 1956, pp. 125–28.

ing families, as well as for those requiring assistance of various kinds.

Most of the postwar budget standards, prepared for self-supporting families, describe a level of living which meets the necessary minimum "as determined by prevailing standards of what is needed for health, efficiency, nurture of children, social participation, and the maintenance of self-respect and the respect of others." [5] Improved scientific knowledge of health and nutrition has provided the basis for widely accepted minimum standards for food and housing. Progress is being made in the development of standards for medical care. Improved statistical techniques and a wealth of data on expenditures of families of various types have made possible more objective determination of other items which must be included in the family budget at a specified conceptual level of adequacy.

American standards of living, that is, our ideas of how we ought to live, have risen considerably in recent years as a result of the greatly increased incomes and levels of consumption achieved by a majority of the population. Recent figures from the Department of Commerce show that in 1958 average family personal income was $6,220 before Federal income taxes, and $5,610 after taxes. After allowing for changes in prices, this represents an increase in average family purchasing power of 18 percent since 1947 and 38 percent since 1928. Since income is the most important single factor affecting total expenditures, it is not surprising that a similar increase in the level of consumption per family has occurred.

These changes were, of course, not uniform across all groups in the population. Incomes of wage workers rose more sharply than those of salaried employees, and incomes of retired persons lagged behind those of employed persons. Studies of family expenditures show the changes in spending which accompanied these changes in purchasing power. These changes, too, varied among the different kinds of goods and services, reflecting changes in production and distribution, in methods of financing, and in family composition and manner of living. Thus, current spending patterns are the

[5] *Workers' Budgets in the United States,* Bureau of Labor Statistics Bulletin No. 927, p. 6.

result of the complex interaction of many factors, both economic and demographic.

Comprehensive data on family expenditures are not available on a continuous basis but are obtained at infrequent intervals by the Bureau of Labor Statistics for urban families and by the Department of Agriculture for farm families. Since most standard budgets have been designed to measure the adequacy of urban family income, only urban family expenditures will be considered here. Surveys were made in 1941 and 1950, and estimates of the 1956 pattern of spending were derived from trend data. In terms of dollars of constant purchasing power, average consumption expenditures of urban families increased by about 22 percent between 1941 and 1956. Considerably larger than average increases in net expenditures, that is, adjusted for price change, were reported for some important categories of goods and services: transportation (37 percent); medical care (48 percent); housefurnishings (45 percent). Total housing expenditures increased about 30 percent, the same as for recreation, reading, and education combined. It is evident from these estimates that there was a sizable net gain in the level of living during these years. If comparison is made with the 1934–36 survey data, even greater gains are apparent.[6] The effect of this may be seen in the levels described by postwar budgets. Postwar costs of "modest but adequate" budgets for self-supporting families, roughly deflated for price change, range from about 30 to 60 percent higher than the "minimum comfort" budgets—the most generous budgets of the early twenties.

During the first third of this century, most city worker families had a relatively simple manner of living. They were predominantly renters who lived near their places of employment. The wife did not work outside the home. The home was equipped with relatively few mechanical gadgets. Installment credit was not extensively used. Processed foods were less prevalent than now, and marketing facilities were, by today's standards, simple. There was,

[6] For details on changes in city family spending see Faith M. Williams, "Standards and Levels of Living of City-Worker Families," *Monthly Labor Review*, LXXIX (1956), 1015–23; Helen Humes Lamale, "Changes in Expenditures of Urban Families," *Journal of Home Economics*, L (1958), 683–87.

also, considerably less understanding of nutritional and health requirements.

The average city worker's family lives quite differently today. The increased availability of long-term mortgages and liberal home-purchase financing granted veterans in the postwar years have changed the average city family from renter to owner. Ownership of nonfarm dwellings increased from 41 percent in 1940 to 59 percent in 1956, and most of the new owners have mortgages. Families in the postwar years have also greatly expanded their use of installment credit for purchasing furniture and equipment for their homes. With the trend to homeownership came the move to the suburbs and the well-known attendant changes in living habits and requirements. The automobile has taken on a new order of importance for the average family. Also, as is well known, a much higher proportion of wives are now employed outside the home. This has resulted in new preference patterns for various commodities and services, and reappraisal of the priorities assigned to different purchases.

The effect on our standards of living of what are often called "revolutionary" changes in production and distribution of goods is, perhaps, most clearly revealed by our postwar eating habits and food preferences. Conveniently packaged and attractively advertised foods, more widespread knowledge of nutritional requirements, and the efficiency of modern refrigeration have radically altered the food purchasing patterns of most American families. Postwar studies of food consumption, analyzed by the Department of Agriculture, reveal the greatly improved diets and wider variety of foods consumed by families at all income levels. Technological changes in production and marketing and better consumer education have affected practically all categories of spending. Advances in medical care and better understanding of the importance of preventive treatment have changed our standards and spending patterns for these services.

What does all this have to do with our concepts of income adequacy and standards of adequate living?

Before the mid-thirties, when the manner of living of the great majority of city families was relatively simple, the "living-wage"

concept of income adequacy was the usual basis for defining adequate living standards for self-supporting families. The level of living specified in budgets based on this concept was described as a "minimum for health and decency." There was usually some recognition that a living wage should provide some "comfort," but such "comforts" as were included in budget standards were definitely minimal in the precise sense of the word, the least possible from the "health and decency" standpoint.[7]

Translating a budget concept into a list of goods and services which accurately describes the level of living intended by the concept has never been easy. But it was very much easier to do when the manner of living was simple, and the total goods and services available to, and used by, most city worker families were quite limited. In that era, the distinction between necessities and luxuries could be and was based on physical needs, as then understood.

Postwar changes in the manner of living of urban families make it virtually impossible to classify the many items used by present-day workers' families as "necessities" or "luxuries." Is the car a necessity or a luxury when the family lives in the suburbs? The same question may be asked of a substantial part of the goods and services which are the usual purchases of even low-income families today. Furthermore, the social concept clearly specifies that the goods and services shall be the necessary minimum as determined by prevailing standards. Thus, present-day standard budgets for self-supporting families are not minimum in the sense that prewar budgets were.

It is for this reason that the Bureau of Labor Statistics describes its City Worker's Family Budget as providing for a "modest but adequate" level of living. The original report contains a statement of the Advisory Committee on this concept:

> When it is said that the budget recommended is intended to cover the necessary minimum, "necessary" is to be given the common interpretation as including what will meet the conventional and social as well as biological needs. It represents what men commonly expect to enjoy, feel that they have lost status and are experiencing privation

[7] A more detailed discussion of these changes in budget concepts is given in Helen H. Lamale, "Changes in Concepts of Income Adequacy over the Last Century," *American Economic Review*, XLVIII, No. 2 (1958), 291–99.

if they cannot enjoy, and what they insist upon having. Such a budget is not an absolute and unchanging thing. The prevailing judgment of the necessary will vary with the changing values of the community, with the advance of scientific knowledge of human needs, with the productive power of the community and therefore what people commonly enjoy and see others enjoy.[8]

This is an important conceptual consideration in the use of this type of budget in administrative and legislative programs. Such budgets may appropriately be used only if their defined conceptual level is consistent with the goals established for the program.

Another factor, resulting from, and contributing to, the shifts in our levels and standards of living in recent years, is the variety of new resources available to families to supplement their current money income. Perhaps even more important than mortgage and installment credit, but also more difficult to evaluate, is the effect of insurance programs of all kinds.

The first standard budgets in this country were developed at the turn of the century after rapid industrialization, growth of cities, and successive waves of immigration had created serious slum conditions and a new kind of poverty in our cities. Then, the needy included great numbers of city workers, as well as the old, the young, and the unemployable. Many of these workers had migrated to the cities from farms and small communities where home-grown food, free fuel, and other nonmoney income covered an important part of their living costs. In their new city homes, they were cut off from these resources and were forced to live on wages. These were often inadequate for current needs and did not provide any reserve against emergencies.

Today, new forms of nonmoney income are available and used by city families at all income levels. These include the many community services provided from public funds as well as from unnumbered private sources. Assigning a money value to these items is generally impossible, but they undoubtedly have an important effect on the way families spend their current income and on their standards of living.

Various programs adopted to insure income in normal and

[8] *Workers' Budgets in the United States*, p. 5.

emergency situations, such as minimum wage laws, unemployment compensation, Old-Age and Survivors' Insurance, public and private health and welfare funds, have greatly increased the resources available to the average family. They not only have altered our manner of living but have also changed our ideas of the relative responsibilities of individuals and government for the care of the needy; have affected our attitudes on the relative merits of spending and saving; and have influenced our concepts of the adequacy of current income in different situations.

In recent years, attention has been given in important theoretical and statistical studies to the definition of income as it affects current spending. These studies are providing clues to how families evaluate their current income status in relation to their past income and potential future income. The effect on spending and on current needs of such other resources as inventories of durable goods, equities in owned dwellings, and credit facilities is being investigated. The findings of these studies have an important bearing both on the estimates of standard budgets and on estimates of need for various groups in the population, based on the costs of these budgets in relation to the total resources available to the families or individuals involved. These research results are also important considerations in estimating future needs and planning programs to meet these needs.[9]

Since the early years of this century, research to develop standard budgets which define specific levels of living has been carried out by the Bureau of Labor Statistics, other Federal, state, and local agencies, and by numerous private organizations. From the beginning of standard budget-making it has been recognized that the concept of the level of living on which the budget is based is subject

[9] Some recent analytical studies of family income are: *Family Income and Buying Power*, U.S. Income and Output—a Supplement to the Survey of Current Business, U.S. Department of Commerce, November, 1958; *Income Distribution by Size—1955–58*, Survey of Current Business, April, 1959; *Detail of Family Accounts*, Vol. XI of Consumer Expenditures Study, BLS-Wharton School, University of Pennsylvania, and analytical studies at the University in conjunction with this program; *Reports of the Interderpartmental Committee on Low Incomes*, New York State; *Studies of Adequacy of Unemployment Insurance Benefits* being made by the Federal and State Bureaus of Employment Security.

to considerable variation and will have an important effect on the resulting estimates of budget costs. Before the Second World War standard budgets were primarily a tool for use by welfare agencies or as a means of evaluating incomes of self-supporting families at very low economic levels. As such, they did not consider many questions which concern the budget-maker today. The many factors which we have discussed, which have affected our concepts of adequate living standards, have also caused a greater diversity of budget standards and more need for budget cost estimates. The problems of developing and using standard budgets have been greatly increased by this diversity of uses.

Today, estimates of standard budget costs are needed along a broad range of consumption levels to serve a wide variety of purposes. At the lower end of the scale, budget standards are needed for legislation and administration of assistance programs for both short-run and long-run situations. Budget standards are needed to evaluate the adequacy of income from minimum wage levels to the considerably higher economic levels considered in planning and administering such programs as emergency medical aid, educational grants, etc. Although differences in levels and standards of living among various regions and occupational groups are undoubtedly fewer today than before the Second World War, one of the important uses of standard budgets is to measure differences in living costs from place to place and from one type of family to another. Estimates of the cost of adequate living standards, when analyzed in connection with income distribution, provide the guides necessary for social and legislative programs dealing with wages, prices, credit, public assistance, taxation, etc.

The most recent Bureau of Labor Statistics budgets are the City Worker's Family Budget, developed in 1946–1947 and last priced in October, 1951, in thirty-four large cities, and the Elderly Couple's Budget, developed in the Social Security Agency in 1947 and last priced in October, 1950, in the same thirty-four large cities.

Thirteen states have minimum-wage budgets for working women, most of which were developed prior to or immediately

following the Second World War. Except in a few instances, current costs for these budgets have been based on estimates of price change since their original pricing.

Many standard budgets have been developed by state and local governments and by private agencies in connection with assistance and welfare programs of various kinds. Some of these have a carefully defined conceptual basis for the level of living they attempt to define, and the selection of goods and services covered by the budget has been made in accord with acceptable statistical procedures. More frequently, however, these standards are adaptations of the Federal agency budgets or allowances more or less arbitrarily determined by subjective methods or by the funds available for the purpose.

The Bureau of Labor Statistics has not issued current estimates of the costs of the City Worker's Family Budget and the Elderly Couple's Budget because these quantity budgets were based on standards prevailing before the Second World War and are not representative of postwar standards. In recent months, we have been using postwar expenditure data to develop revised quantity budgets for both these budgets. We expect to have funds for the next fiscal year with which to price these budgets in a number of large cities throughout the country.

The City Worker's Family Budget is designed to provide a "modest but adequate" level of living for a four-person family—husband; wife, who does not work outside the home; a teenage boy; and an eight-year-old girl. The budget specifies a five-room, rental dwelling which meets a well-defined standard. The Elderly Couple's Budget is designed to provide the same standard for a retired couple who occupy a rental dwelling. We hope to be able to work toward the development of budgets describing some other family situations, such as a home-owning family. At present, our program is limited to a revision of the two previously published budgets.

We are also analyzing the 1950 expenditure data to develop relative scales which may be used to estimate the approximate cost for families of different size, age, and composition. These will provide only very rough estimates for benchmark purposes and not the

refined statistics required for specific administrative purposes. Too often, these general budgets for self-supporting families of a specified type are used administratively, with little concern about the appropriateness of the level of living they describe in relation to the program objectives and to the community situation.

Administrative use of budgets requires a "family" of budgets from which that appropriate to the specific use may be selected. This calls for continuing research in connection with each program to define appropriate budget standards and measures of budget costs applicable in the local situation.

There is a continuing need from the national to the local level for research designed to define clearly program goals; to decide the level of living consistent with these goals; to determine the cost of the specified living standards; and to appraise the needs and resources of individuals and families in relation to the needs and resources of the economy.

Planning for the Small Community

by REGINALD ROBINSON

THERE HAS BEEN A GROWING CONCERN over the plight of small communities. In these towns, whose populations range from 2,500 to 50,000 live more than thirty-five million people. Many of us have felt for some time that they offer a great opportunity for development. However, efforts so far to lend assistance—financial, consultative, or through research and demonstration—have been feeble, sporadic, and halfhearted in the light of their needs and their capacity to respond.

Attention has been centered largely on the bigger cities and the rural areas. In the first three decades of the twentieth century, effort was devoted to the large urban centers where the problems were acute and there was professional and citizen leadership to create and maintain community services. More recently, agricultural, economic, and welfare interests have been working on development in the sparsely settled rural areas. Both these movements were timely and important, but the small communities with serious problems of their own and equal potentialities have been largely neglected and have lagged far behind.

Another reason for our failure to organize effectively to help small communities develop their health, welfare, and recreation resources is that we have not had the telling facts necessary to arouse public interest and enlist support. Those who work in the field know from experience some of the problems faced by the small community, but we have had no way to present to the public the full picture with supporting data.

We are now in a better position in this respect. The United Community Defense Services analysis of the situation they found in small communities and a current study by the Joint Commission

on Mental Illness and Health, made for its report to Congress, provide an array of facts that support our impressions. Small communities are, indeed, poorly supplied with the basic community services that we are accustomed to in the big cities. Here are a few of the findings:

United Community Defense Services studied the availability of services in the 255 small communities with which it worked between 1951 and 1956. We checked the presence or absence of the following basic services in each community:

1. A full-time local health unit
2. A public health nursing service for care of the sick in their homes
3. Provision for "general assistance"
4. A year-round public recreation program
5. Private agency leisure-time programs with provision for younger boys and girls, teenagers, and youth
6. Probation service in the juvenile court
7. Mental health clinic service
8. Family counseling service
9. Public or private child welfare services
10. Casework service for transients and nonresidents
11. Central fund raising with executive staff
12. Community planning with executive staff

We found that, on the average, the whole group possessed less than half the full set of services. The smaller the community, the more likely it was to be without many of the basic programs. The ninety-two communities with less than 10,000 population had on the average only four out of the twelve items, and thirty-five towns had fewer than four.

The Joint Commission conducted a study of the supply of much the same range of community services in all the 3,103 counties in the country and scored each one on a scale of one to 50.

We found that the small counties with less than 50,000 population had a median score of only 16 out of a possible 50. Those with over 50,000 population had an average score of 34. Again, the smaller the county the lower the score. The counties with between 5,000 and 10,000 people scored only 13 on the average. Still smaller

places had lower scores. In contrast, practically all the big counties with over half a million population had scores above 40, and five of them had perfect scores of 50.

The Joint Commission also sought to identify the typical configurations of services now present in different kinds of communities. We realized that no two communities are quite alike but we hoped to find some common elements in the array of local programs.

The basic services in more than half of our sample of smaller counties consisted of a health department, public health nursing, a public welfare program, group work programs for children (usually scouting), Agricultural Extension Service, and either a probation service or a child welfare service or both. Missing in almost all were psychiatric resources, family counseling service, and community planning and fund raising with professional staff. Only 18 percent had a public recreation program.

Even the available services were none too strong. In only 9 percent of the counties were there enough public health nurses to meet the minimum standard. In only 13 percent were there funds to provide more than a token general assistance program. Private agency group work programs were limited generally to scouting for younger boys and girls. In less than 10 percent of the counties was there probation service for all the courts. Public child welfare service was found in less than 40 percent of the places. We knew that the configurations of resources in these counties would lack some of the key services, but it was discouraging to find so little offered by those that did exist.

In addition to these statistical studies the Joint Commission conducted intensive field studies in fifteen counties, including a number of small ones, which revealed additional weaknesses. Let us look at two of these counties closely.

The first is an agricultural county in a Southeastern state. In 1956 the county's population was 93,000, although the largest and only urban center had but 14,000 people. Nonwhites constituted 57 percent of the population. Four district school systems were operated because of segregation among whites, Negroes, Indians, and an Indian-Negro subgroup. Seventy-five percent of the farm

homes lacked running water, and 20 percent had no privies.

The infant death rate was about 50 percent higher than that for the state. The maternal death rates over a five-year period were about 50 percent higher than those for the state and between two and three times those for the United States as a whole. Illegitimacy was high in the rural areas of the county. One fifth of the nonwhite children were born out of wedlock in 1955. There were sixteen homicides in 1955, giving the county a rate over four times that for rural areas in the United States.

The community services were as follows:

The Public Health Department, established in 1911, had developed a wide range of services. However, it was largely absorbed in control of communicable disease and in child and maternal health.

A broad public welfare program under the county department included public assistance (with a very small general assistance program), probation and parole, visiting psychological service, boarding homes for the aged, foster care, and adoption of children. This wide range of services followed the pattern and policy of the state public welfare administration. The staff consisted of a director, a graduate social worker as staff supervisor, and six caseworkers with bachelor's degrees and in-service training only. Staff assigned to the child welfare services were also untrained and carried high case loads made up of many disturbed children and broken families. In fact, the department was a major center for service to people in all kinds of trouble.

Truancy was an acute problem, but there were only four visiting teachers (not graduate social workers) to cover the entire county. A screening procedure for health defects turned up a small number of children with behavior and emotional problems. Some were referred to the public health nurse, some to the welfare department, and half a dozen to the mental health clinic in the next county.

This clinic, located forty miles away, served several other counties as well. It had a part-time psychiatrist two days a week and accepted only emergency cases.

The general hospital had one room for mental patients but it was not used. There was no psychiatric service here, and patients

awaiting commitment were held in the jail. The jail was new, but not suited for detention of mental patients, who were looked after by trusties. The nearest inpatient service was 100 miles away.

There were no psychiatrists in the county. The nearest psychiatrists in private practice were eighty miles away. A few referrals were made to them.

The county court relied on the public welfare department staff for social studies and recommendations on juvenile and domestic relations cases and for supervision on probation. Police also referred children in trouble to the public welfare department.

There were Boy Scouts throughout the county and two YMCA boys' groups in the city. Staff leadership for all these groups came from outside the county. No recreation or group work programs for girls, young people, or adults were provided by private agencies. In the urban center there was a full-time public recreation program under a trained director. A large 4-H and Home Demonstration program included all ethnic groups. Group loads per staff worker were high.

Our second example is an oil-boom county in the deep Southwest now gradually settling down after a period of rapid growth and change. Until ten years ago it had been an agricultural county and still possessed 940 farms. Its urban center had an estimated population of 17,610.

The rapid and substantial increase in wealth in the county had resulted in an uneven community development. The people had built a school system costing $8,000,000, a new library, a park, a new community hospital, a nurses' home, a county health center, a women's club, churches, and many palatial homes. On the other hand, because the city had only recently adopted a zoning ordinance, there was a haphazard distribution of dwellings and business structures. Housing for the 650 Negroes and Latin-Americans consisted of miserable hovels in squalor and filth on the fringe of the city. The urban center had wind-blown, dusty streets and an ancient courthouse squatting in the town square.

The incidence of social and health problems was about average. Alcoholism, however, accounted for most of the inmates in the county jail, and there was a flourishing chapter of Alcoholics Anonymous.

Community services were as follows:

The county health department was part of a three-county district with a full-time health officer. The local staff consisted of a sanitarian, one public health nurse, and a secretary. The nurse made few home visits.

The public welfare program was administered through two different units. The state administered categorical assistance through one untrained worker stationed in the county. The county welfare department, also consisting of one worker, distributed surplus food commodities, paid out some monies for medical care and to homes for the aged. Families had to be destitute to receive even temporary help. Nonresidents were not eligible for aid.

There was no child welfare worker, trained or untrained, in the county or available to the county. Children were being placed in free, unlicensed foster homes by an untrained probation officer, the county attorney, doctors, and others.

There was no public recreation in the county. There were active Home Demonstration and 4-H club programs, a strong Boy Scout program (part of a three-county district covered by one staff worker), and a Boys' Club with an untrained director. There was no organized, private program for teenagers or for girls of any age.

The county was one of very few in the state with a juvenile probation officer, a former deputy sheriff. Untrained and lacking in understanding of children and their problems, he placed children in free foster homes which were unlicensed and unsupervised. This officer was not in touch with the school pupil-personnel services which possessed trained and skilled staff. There was an adult probation officer under the state program who covered six counties.

The school system in the county seat had a high-grade pupil personnel service consisting of two visiting teachers (graduate social workers), two nurses, and two trained counselors. This program had been instituted and partly financed by the state mental health authority as an experiment. There was resistance to it on the part of teachers, principals, and school board members in spite of efforts toward understanding and orientation.

The sheriff, a key figure, was sympathetic and understanding of children and of emotionally disturbed people. He arranged for offenders who acted "queerly" to be given a medical examination

by the county doctor. Youthful offenders were held in the juvenile section of the jail. There were no juvenile police officers, and the regular police were reported to be overzealous in arresting children.

Private mental patients were admitted to a proprietary hospital for forty-eight hours pending transportation to private mental hospitals at a distance. Other patients were detained in the county jail.

There was no psychiatric service of any kind in the county. The only follow-up of mental patients was done by the sheriff on an informal basis. The county physician examined (with another doctor) the mental patients referred to him by the sheriff and police.

In these counties and their counterparts throughout the country services were very limited in scope and had few trained workers to provide high quality of program. The counties were lucky to have even one graduate social worker. Public assistance grants were often below subsistence standards; eligibility restrictions kept many needy off the rolls; protective and treatment services for children were either missing or primitive in the extreme. Except for Agricultural Extension Service, recreation and group work programs were operating mostly in the county urban center and were without full-time professional leadership. The center for the care of the mentally ill was almost without exception the county jail, and the key figure in the program was the county sheriff. If these counties were typical, and we believe they were, this is the best that can be said for almost half of the counties in this country.

From such studies as these we are garnering facts to support our contention that small communities are undersupplied with basic services and that those that are present are often far below the standard of those in larger cities. If we are to enlist interest in the plight of such communities, however, we must be prepared to offer some practical proposals for action.

Let us first dispose of the notion that the task of improving programs in small communities is hopeless. This fallacy (long a ready excuse in some quarters for doing little) was disposed of by the experience of United Community Defense Services in helping 255 such towns develop their health, welfare, and recreation programs. Fifty-six new program units were established in these communities

within a five-year period, and eighty-four committees were organized to sponsor new programs. Additional public or private funds were secured to support programs in forty-nine instances. Thirty-six places organized new community planning councils, and twenty-two new chests or united funds were set up. In ninety-four communities more than one such major change took place, and in eight areas there were ten or more such advances. Many state departments of health, of welfare, and of education can show similar dramatic developments among their smaller counties.

It is heartening to note that attention is being given to the special needs of small communities and the configurations of services appropriate to meet them. We have mentioned the research conducted by the United Community Defense Services and the Joint Commission on Mental Illness and Health. Other research or demonstration programs on services in small communities are being carried on by the U.S. Public Health Service, by the National Institute of Mental Health, by some national voluntary agencies, by the Office of Education, the Bureau of Public Assistance, and other national, state, and voluntary bodies.

While it is far too early to report conclusive findings, the inquiries to date suggest that programming for small communities may take the following directions:

1. Local planning and actual development of services will be conducted at the county (not the town or village) level and sometimes through combinations of several counties.

2. For the development of casework services, the county welfare department and the child welfare program seem to offer the best potential as the locus of the service. Only in the fortunate few counties that are prosperous and have unusual leadership can we expect private agency service to develop to any extent.

3. For the development of group work, recreation, and leisure-time services, we will look to the scouting programs, public recreation, and the Agricultural Extension Service.

4. For outpatient psychiatric service in the foreseeable future, many counties will have to share a minimum supply with other counties or districts and cannot hope to possess their own. Inpatient facilities may be forthcoming through attention to needs for psy-

chiatric beds in community hospitals, the only hope for stopping detention of the mentally ill in jail.

5. For probation service, there will be some local developments, but we may also look to state-wide probation programs and, in some areas, to child welfare services.

6. For special services in the schools, we look for increases in local psychological services within the school system itself.

7. For more adequate public assistance, we shall be dependent to some extent on broadened local policy, but probably in a larger measure on state and Federal advances.

Four things seem to be needed: consultation to local communities; money; manpower; and research. These elements are all present in varying degrees but are in short supply. Let us look at each of them briefly.

The development of community programs will be very slow and ragged without consultation and help from outside the county. The services small communities now possess have come in large measure from stimulation and help from state departments of health, of welfare, of education, and from national voluntary agencies. State departments are limited, however, in their capacity to provide full consultation service even in their own specialties. So are national voluntary agencies. Federal agencies' relationships are usually with states and not with local communities. Thus, progress in the local community is dependent in many ways on consultation from the state level and on such national efforts as those of United Community Defense Services.

We must expand this consultation service and in doing so give attention to a corollary problem. Much of the consultation now available is provided by specialists skilled in the development of specific aspects of the community program. We also need service from consultants able to advise on the balanced development of the over-all array of resources, to help communities select priorities, to work for the configuration of services most suitable in each local situation, and to help communities organize to get action. The smaller the community, the more desperate the need for this kind of help.

I am reminded of a small county of 35,000 population where

this kind of generic approach was badly needed. The county health department was being urged by the state to establish a mental health clinic and to assign the public health nurses to follow up former mental patients discharged from the state hospital. Meantime, the health department was fighting a widespread rabies epidemic throughout its three county districts. Mental patients awaiting commitment were housed in the dilapidated county jail, the overburdened public welfare staff was without local funds for general assistance. There was only one graduate social worker in the county, no psychological service in the schools, and only a part-time probation officer whose treatment program was conducted with the use of a large paddle he kept in his office. The community hospital had a psychiatric ward, but it was closed because the doctors, nurses, and the administrator were afraid of mental patients. I wondered whether the psychiatric clinic was the single answer.

Few small communities can meet the full costs of needed services. Most of them have few resources of their own. State and Federal funds are available in certain fields, such as public assistance, education, public health, child welfare, and, more recently, in mental health. Small communities in states where such funds are more generously provided show more progress. Whereas all local communities need the stimulation and help of these funds, the average small community is desperately in need of them.

Studies of the supply of manpower so badly needed for expanding programs are all discouraging. The current inquiry by the Joint Commission on Mental Illness and Health is no exception. There are great shortages in all the professional specialties, and we are falling further and further behind. There seem to be only two answers to this problem. One is a crash program of recruiting and training people for all the helping professions by means of a great expansion of training centers and substantial subsidy; the other, a greatly intensified in-service training and staff improvement program for the workers now in the field. This too calls for a real investment of money, but it will show results quickly while a long-range program is getting under way.

Some attention is being given to research on programing for small communities. The U.S. Public Health Service, the National

Institute for Mental Health, and the Joint Commission have studies under way with respect to programs and structure suitable for small counties. Some national voluntary agencies, such as Family Service Association of America and the YMCA, have projects on development of service to small communities, and some foundations, such as the Rosenberg Foundation in San Francisco, have been giving attention to these problems. Taken all together, however, research is only beginning to give us guideposts for the long road ahead.

We need a program involving the various interests and services concerned with small communities. Each specialty should expand its study and development of services, but these separate efforts would all be more effective if there were ready communication and joint planning among them. In this way sound, over-all patterns of community services could evolve. A joint national effort including research, experimentation, and demonstration, not just of one phase of the community program but of all in relation one to the other, could supply the needed impetus for developing appropriate services for small communities.

New Trends in Adoption Practice

by MILDRED ARNOLD

ADOPTION IS AS OLD as human history—and as new as our dreams of a secure and promising future for all children.

It presents problems as old as civilization—and as new as the present struggle to conquer outer space.

For those in social work, adoption brings problems with which we have been concerned for a long time—and with which we have, in some respects, made discouragingly slow progress in the past.

But in evaluating new trends in adoptions I think we will find not only that they are creative and exciting but that they are evolving on a sound base. This sound base, it seems to me, is clearly visible in improved state legislation embodying fundamental protections in the law for the natural parents, the child, and the adoptive parents—and also in the fact that it is built on the experience of a qualified, professional service and on a growing understanding and appreciation by the public of what is involved in this intricate and delicate process.

Nothing can be more intricate or more delicate than terminating the parental rights and responsibilities of one set of parents and then establishing completely new ones with another set of parents for the same child. What area in the whole field of social welfare carries such heavy responsibility or such long-term implications for all those involved in the process?

To be sure, it is the court that actually terminates parental rights and establishes new ones. But social agencies have the responsibility for helping parents or others decide that such rights should be terminated forever and then for selecting the family best able to meet the peculiar needs of a particular child.

In addition to the serious responsibilities this process carries, no

aspect of social welfare practice deals with situations involving so much emotion and feeling. Nor, I hasten to add, is there any area in which so many people feel that they are qualified to assume these responsibilities, as serious as they are. Probably this is so for many reasons. Some are quite obvious and easily understood. Others have deep emotional significance. And still others reflect our culture and the changes in our socioeconomic life.

Ancient and modern cultures, for the most part, have had their foundation in the family. With such deep roots in our culture, it follows inevitably that if a family with children cannot be achieved by natural means, other ways will be sought. Families took other people's children as their own long before social agencies came into existence. Indeed, adoption goes far back into history, even to Biblical times. So, not too surprisingly, some of our problems in the adoption field can be traced back to the fact that social work is a relatively new profession.

Then, too, the pressure of modern times lies heavy on adoption. It is the vogue now not only to have a family but to have a larger family than was previously the fashion. Not only are childless couples eager to obtain someone else's children, but many who can have only one or two of their own wish to enlarge their family by the same means.

The picture is complicated further by the fact that so much of this problem centers around the unmarried mother—and here emotions run high. In what other situation do we find such extremes in feelings and so much conflict? Perhaps the best evidence of this lies in our ambivalence as a country in providing public assistance for unmarried mothers.

Despite the number and seriousness of the problems we have made remarkable progress in recent years in the field of adoption. Our progress is reflected in new and improved state legislation, increased availability of adoption services by social agencies, improved and more flexible adoption practices, better teamwork among the professions directly concerned, particularly the social, medical, and legal professions; better public information through magazines, newspapers, and television as to what is involved in this

complicated process and, hence, a better understanding on the part of the public.

For decades our states have struggled to provide legislative safeguards in adoptions, and state courts have given judicial recognition to the validity and importance of these protections. One thing stands out crystal clear. The more closely adoption legislation is woven into the tapestry of the state's related law, both substantive and procedural, the more effective it is.

Today, many of our communities recognize that the welfare of children, natural parents, and adoptive parents makes imperative that parental rights be terminated through a judicial procedure prior to placement of a child for adoption, that adoption placements be regulated, that social studies of adoptive homes and a period of agency-supervised residence of the child occur before the adoption decree is granted. Most state laws provide these safeguards in one form or another although states vary a great deal in these matters, and some have better safeguards in certain aspects of law than others. In most instances laws appear to be stronger with regard to social studies and supervised residence than they are on termination of parental rights and on the regulation of adoptive placements. The Children's Bureau is now engaged in developing principles and suggested legislative language relating to termination of parental rights and may next turn its attention to principles and legislative language relating to the regulation of adoptive placements.

Skilled adoptive placement becomes the pivotal point upon which a successful adoption turns, particularly if it has been preceded by adequate concern for the severance of parental ties, a social study of the child and adults concerned, and groundwork for a period of residence in the adoptive home with guidance and help from a social agency. A new trend around this pivotal point in adoption may be in the making, if some of the new state laws foreshadow future laws in other states. In Connecticut and Delaware, legislation requiring agency placement in all non-relative adoptions has been passed. In these two states, the courts cannot accept adoption petitions in the absence of such placement. The inci-

dence of independent placements with their manifold dangers should be eliminated by this means.

Our experience demonstrates that the efficacy of legislative safeguards in adoption depends in large measure upon better regulation of child placements in general, the provision of services to unmarried mothers, and the availability of adoption services by social agencies. Progress has been made in these areas, too. The so-called "independent" placements have long been of concern to us. That these have been decreasing is evidenced by the fact that in 1957, 60 percent of the adoption of children by persons unrelated to them was done through social agencies. Until only recently well over 50 percent of such placements were made through other channels.

Despite many discouraging developments relating to services to the unmarried mother, some rays of encouragement can be seen on the horizon. Take, for instance, the bill passed by the state legislature in New York and signed into law on April 20, 1959, by Governor Nelson A. Rockefeller. This law gives to the public welfare official the discretionary power to waive the investigation of legally responsible relatives of an unwed mother, if such action will be in the best interest of the mother and the child. The law provides that this decision shall rest in the discretion of the public welfare official in view of all the facts and circumstances present in such case. In signing this bill, Governor Rockefeller issued a special memorandum in which he said:

> In my Annual Message I stated that: "Child welfare programs should be given continuous attention to the end that they meet current needs." I mentioned adoptive services as one important area of concern. This bill takes a significant step in helping to strengthen adoptive services in this State and to reduce the number of babies who are placed for adoption, through the black market or gray market.

The interest and concern of other professions in assuming their rightful role in adoptions and in working with the social work profession were demonstrated in three successful meetings held by the Children's Bureau in the last two years. These meetings resulted in three publications setting forth the social worker's, the physician's, and the attorney's roles in adoption. This material is

being presented to strategic groups throughout the country; namely, national organizations such as the American Medical Association, American Bar Association, the American College of Obstetricians and Gynecologists, and their state and local counterparts.

Social workers can be proud of these accomplishments in the adoption field because all of us have had a part in many of them. We have dared to look critically at our own practices and, in many instances, as a result, we have changed them. We have been able to say forthrightly that this field is not ours alone, that many others must share responsibility with us. We have worked with others in getting better laws passed; and in making more services available to the unmarried mother and her child. We have spent many hours interpreting to the public what these services mean in better protection for natural parents, for their children, and for adoptive parents.

I would not give the impression that I think our job is anywhere near completed; or that we have always pursued these endeavors with all the vigor we should. But beginnings have been made, notable achievements have been chalked up, and we have contributed to them.

I am frank to say that in another area of adoption we are disheartened, and we view with apprehension many things that have been happening. I speak of the field of intercountry adoptions!

As a country we have been sympathetic to opening our shores and our homes to those children needing them because of the havoc wrought by war and its aftermath. Over the years our immigration laws have allowed individuals and families seeking new opportunities to come to this country. But it was the Second World War that opened the way for children to come here to find homes, if only on a temporary basis. The terrible bombings of the cities of England led to an Attorney General's order on July 13, 1940, designed to facilitate the entrance of children from European war zones seeking refuge in the United States and to assure proper care for them after arrival.

The U.S. Committee for the Care of European Children, a voluntary agency, was organized to clear the way for the admission

of children evacuated from these zones in large numbers and to assure their proper care in this country. Under a Presidential Executive Order, the Children's Bureau was given specific responsibility in this program. The Bureau set standards and designated the local agencies that were to study the homes and supervise the children. The Bureau assigned staff to this effort and worked closely with the U.S. Committee. It maintained a register of all children who came to this country.

This was just the beginning of an almost continuous stream of Executive Orders or new legislation allowing homeless, uncared for, and unwanted children to find refuge in our country. In 1945 a Presidential Directive opened immigration to orphans on a regular quota basis. The Displaced Persons Act of 1948 followed, authorizing 5,000 special nonquota immigrant visas (later amended to authorize a total of 10,000) to be issued to alien orphans adopted by United States citizens. During the lifetime of this law 4,065 orphans were admitted. Here again at the request of the Commission, the Children's Bureau set standards and designated the local agencies to provide services. This law expired on June 30, 1952.

The Refugee Relief Act, enacted August 8, 1953, allotted 4,000 nonquota immigrant visas for alien orphans, and the total number of visas was issued. An additional 925 children had failed to obtain visas by the date the Act expired on December 31, 1956. Through a special authorization, they were paroled to this country. Most of these paroled cases involved servicemen and their wives or other governmental employees stationed abroad.

The Department of State was responsible for the administration of the Refugee Relief Act. The Children's Bureau assisted the Department in the development of their regulations and provided continuing consultation service. As under the Displaced Persons Commission, the Department of State used international voluntary agencies designated for this purpose. The regulations stipulated that local agencies must be licensed or otherwise approved by the State Department of Welfare in each state.

Nine months elapsed between the expiration of the Refugee Relief Act and the passage of the present act, Public Law 85-316.

Enacted on September 11, 1957, this law is due to expire on June 30, 1959. The responsibility for securing assurances that a child coming to the country to be adopted here will be properly cared for and that the preadoption requirements of the state of the orphan's proposed residence have been met was given to the Attorney General under the new law. This part of the program is being administered by the Immigration and Naturalization Service in the Department of Justice. Unfortunately, the law carries no such protections for those children who have been lawfully adopted abroad by a United States citizen and spouse.

Many things are happening at the present time that deeply concern social agencies and social workers. First of all, I hope we accept the fact that for many years to come our country can contribute to the welfare of some children overseas by offering them good, permanent homes here.

As social workers, we all feel that countries should be helped to provide the kind of life for their own children which will permit them to grow up healthfully and wholesomely in their own countries with their own families. And to this end, we certainly support all efforts toward improvement of the so-called "developing" countries.

But, in addition, we must be realistic and face the fact that wars, hot or cold, wreak great devastation on countries and in people's lives, particularly in children. The stationing of troops in foreign countries especially leads to problems. For a long time to come, some overseas children will be better off if they are given the security of an adoptive home in another country.

In intercountry adoptions we are, first and foremost, concerned about whether or not these children, already seriously handicapped in so many ways, will have the protections so essential to their future well-being and happiness when they start a new life here. Many of them have had a poor start in life—improperly fed and cared for, shifted from place to place, and without knowing what a real home is. Some are of mixed racial background and have perhaps been scorned in their country of birth. Usually, no social agency has been concerned about whether or not their parents' rights have been protected or whether separation of mother and

child is the best plan for both. The security of a judicial termination of parental rights is often missing.

While the law provides that children coming to this country to be adopted have certain protections, it is completely silent about those adopted abroad. Because of pressures from many families eager to adopt children and to get them quickly—and the misguided interest on the part of some individuals in advancing these hasty arrangements—most of the children now coming to this country are those who are being adopted abroad.

The method of adoption by proxy, though it had its beginning under the Refugee Relief Act, has come into full bloom under the present Act. The Immigration and Naturalization Service reports that between September 11, 1957, and June 30, 1958, a total of 2,040 children had been admitted under the present Act. Of this number, 1,163 were adopted abroad, including those adopted by proxy and by United States citizens who were living abroad when the adoption took place. Of the total, 744 paroled orphans had adjusted their status under the present law, leaving only 133 brought in to be adopted here. It is staggering to realize that the protections spelled out in state laws were applied only to this small number of children. The result, in some instances, at least, is bound to be tragic and unhappy for these children and their families.

While the figures do not show how many of those adopted abroad were adopted by proxy, we can safely assume that by far the majority were brought in by this method. In these situations, a person in the foreign country is given power of attorney by the adoptive parents. When the child arrives in this country and sees his foster parents for the first time, he has already been adopted by them. In practically every one of these situations, a social study has not been made by a social agency and there is no period of supervised residence of the child in the home before the adoption is consummated. Under such circumstances where will these adoptive parents find help in understanding the different customs of the countries from which the children have come? Such help in many instances would smooth the way and increase the chances of

the adoption being successful. A little Japanese boy arrived in this country proudly carrying a large, black kite such as is flown from the rooftop in Japan to proclaim that a boy lives in the house. He could not speak English, and his adoptive parents had no appreciation of the significance of this kite being flown from the rooftop of his new home. They refused to permit it, and had little understanding of the disappointment and shock that followed for the child.

Who is to help parents who are obviously disappointed at the first sight of the child they have adopted? Who is to help the child who has this experience? Take, for instance, the man who wanted to adopt a three-year-old and who treated the eight-year-old who arrived as if she were three, throwing his tall daughter high in the air and carrying her down the corridor of the airport on his shoulders.

Who is to help the parents deal with the embarrassment, fright, and often sheer terror these children naturally show when they first meet their new parents? Who is to stand by to help in those first agonizing days of adjustment of the child to his new parents and of them to him?

Where can parents turn for help for the sorely needed interpretation to the school, the church, the playground, and the community at large when a child from a foreign land becomes part of the family and the neighborhood? Who is to remind the parent that adoption does not mean citizenship and that steps must be taken later if the child is to be a citizen of his new country? Who will help parents with the complicated process of securing a birth certificate for this child, since birth certificates are so necessary to our way of life?

And, perhaps most important of all, who will stand by in case this placement fails? How many of these children run the risk of being passed from one family to another like so many bags of wheat? Take, for instance, the little four-year-old girl whose appearance was so disappointing to her adoptive parents that they gave her to a family they had met at the airport? I do not need to relate the tragedies that can and do occur when children and adop-

tive parents are exposed to such hazards with no resources for help. We will see the human wreckage and heartbreak coming out of such situations for years to come.

Yes, social agencies are justifiably concerned about what is happening to these children. We cannot console ourselves by shrugging and saying that probably only a small percentage of the total will encounter these difficulties. Social work has its roots in the concern for the individual, and so long as individuals are facing serious problems that could be prevented through the services of social agencies, we must be concerned. Our concern as a profession is not diminished when only small numbers of people are involved, and it does not grow simply because numbers grow. We would be untrue to our basic tenets if this were so.

We are rightfully concerned, too, with what these practices may do to the protections in adoption which have been slowly and painfully built up in this country over such a long period of time. When people can quickly secure children through a process which provides no one with any protection, how can we hope to convince legislators, public officials, board members, administrators, contributors and others that protections are needed and that legislation assuring these protections, qualified personnel, adequate financing, and universal coverage of services are essential?

For the most part, I have posed questions, rather than answered them. This is true because no ready answers to all these difficult problems are available. As a country, we must search for answers.

But some things are clear. Some of these problems can be met only through Federal legislation. Many, including the Department of Health, Education, and Welfare, are convinced of this, and several bills have been introduced in the current session of Congress. Protections so sorely needed in these placements must come first through Federal legislation containing the necessary safeguards for bringing these children into this country. I am happy to report that on May 18, 1959, the Secretary of Health, Education, and Welfare announced that, following discussions with the Departments of State and Justice, he had transmitted to Congress a bill to replace the present temporary legislation. This bill would establish authority for issuance of nonquota visas for eligible or-

phans on a permanent basis and would require assurances that any child adopted abroad or brought to this country for adoption will be properly cared for. This bill, then, would extend to children adopted abroad, whether by the adoptive parents in person or by proxy, legal safeguards similar to those which now exist for children adopted after they have been brought to the United States. The bill has been introduced in both the House and the Senate and carries the numbers NR7239 and S2004.

Another significant change from the present law is that in the proposed bill responsibility for determining that such assurances are satisfactory would be vested in the Department of Health, Education, and Welfare instead of in the Department of Justice. It must be emphasized, however, that Congress or the Federal Government cannot carry this responsibility alone. All social agencies, national, state, and local agencies, public and voluntary, have a stake in it and must share it.

The services of state and local social agencies must be made available to these children and their adoptive parents, or all our efforts will fail. To be sure, difficulties are multiplied in this type of placement, such as the expense and time factors of geographic differences, the need for new skills to do "casework by correspondence," the communication problem when the child has a different language from that of the adoptive parents. But we have found from long experience that these difficulties can and must be surmounted.

Gone are the days when we could think of our responsibilities in terms of just our community, our state, or our country. We can no longer speak about "our children" as only those who are our immediate responsibility. In a very real sense, our responsibility for children girdles the globe. We must recognize this in our practice and in our perspective. Social work has a responsibility for the welfare of the people of the world around. Our concepts must grow in every dimension—breadth, height, and time—and who knows, perhaps in the future into space itself.

Individual Change through Group Experience

by ALAN F. KLEIN

GROUP EXPERIENCE PLAYS AN ESSENTIAL PART in the process of maturation. The group seems to meet certain psychological needs, such as the development of independence, the identification of social roles, the development of social skills and attitudes that are acceptable to one's peers and to the larger society, and the development of values that mark growth from egocentricity to socialization. The process is one in which the individual learns to meet his personal needs in such a way as to, at the same time, gain favorable acceptance from others.

For some, group acceptance is a substitute for lack of acceptance in the family. For most it is a logical transition from the period when adult authority and role models are most effective in the family to the years when influence shifts to peer groups and parent surrogates. This shift begins around eight or nine years of age and reaches its height at adolescence. We know that the peer group is a means of providing ego support in and through this transition, on to maturity.

An individual who is denied the acceptance of others gives evidence of maladjustments in the psychosocial maturing process. When one has never belonged in a family or made to feel as though he belonged, for example, it is doubtful that one can belong to, and function in, a peer group by social standards. Such an individual may need to belong so much that the group becomes a tremendous force for conformity. This is usually of a negative quality and therefore stultifying. The influence of group life upon individuals, therefore, is significant in the phenomena of conformity,

moral laxity, and the deterioration of basic social values. The other-directed nature of our culture has made acceptance a criterion of success. Bureaucratization sets up an exaggerated value on the maintenance of its own institutional scheme, and as one of its results the individual loses identity and autonomy. This social situation, coupled with group pressure, can reduce a society to a level of dull mediocrity.

It might be argued that other-directedness is and always has been inherent in democracy. Be that as it may, democracy has been but one force among many in our social history, as part of a social scene that has been shifting rapidly. Let us review some of the components of this social change.

Our neighborhoods in urban areas, and especially the new ones, lack a neighborhood quality. They are impersonal and fragmentized, with little psyche support and nourishment. Child-rearing practices have changed. The nuclear family is replacing the family of orientation. There *is* a loosening of morals or standards of behavior. While other-directedness, and the focus of the immediate, is one value reference influencing us, we also have a residue of deeply entrenched traditional values and some nostalgia for inner-directedness. Family life patterns have changed materially as to function, roles, and tone. When family roles change, and if the marital partners are unprepared for their respective role requirements, conflict may develop. Parents find it difficult to communicate and to pass a culture on to children when it has changed so rapidly that they themselves do not understand it, and have not found a satisfying *modus operandi* within it. These events have been highlighted in the problems of social functioning. We have moved from an economy of scarcity to one of abundance. As the serious problems of physical survival diminish in this country, the social worker can see the upsurge of social problems that are rooted in interpersonal relations and the effects upon people when their psychic needs and personality structures are incompatible with the positions and role prescriptions in which they find themselves.

I suggest that our values have become more difficult to achieve in our current social structure. There have been significant changes in social behavior. Pressures for consensus, group decision, organ-

ization, and conformity would not have had such profound effects alone, but they have been coupled with an increased need to belong as a result of weakened family life, weakened community life, and concomitant needs of individuals to be liked and to have security. There are fewer opportunities for sharp role differentiation, and at the same time there is increasing ambiguity and normlessness. Since parents are less able to prepare children to live in a world such as they themselves have not known, permissiveness arises out of such "not knowing" and is rationalized as freedom. Freedom without inner security and preparation for freedom are frustrating and anxiety-producing.

One may argue that our basic social character has not changed. In ego functioning we see a wider range of reality choices and ego supports are considerably weaker. Supports for the demands of freedom, democracy, and modern living are conflicting for many persons in our culture. Dr. Georgene Seward says: "Modern man has no single pattern to adapt to; he is called upon to function in a complex society where numerous cultural variants operate simultaneously. Adjustment requires integration and a synthesizing of a wide variety of pressures and demands." [1]

In this context the social effects of change in terms of breakdown of strong community and family ties are much more significant to the field of group services than the other-directedness which results from our democracy. Life's journey has become a lonely one from the first separation of babe and mother, through the first experience of a room of one's own, on to nursery school, public school, and thence to a new set of relationships with spouse and one's own life—the journey has become more lonely than in any other society in the world. One has a room of one's own—a private world—with no one to share the fears and anxieties that plague one. The family, the neighborhood, the church, seem to leave all but a few tragically alone. There is no one to talk to who cares or really listens, who has enough psychic energy left to be able to leave his own world of private concern and share another's.

I agree with Dr. Howard Jones, of the University of Leicester,

[1] Georgene Seward, *Psychotherapy and Culture Conflict* (New York: Ronald Press, 1956).

that herein lie the reasons for "the unsatiable urge to belong to clubs, societies, fellowships, fraternities" and that conformity and value disintegration have ensued from this gnawing need to belong somewhere and to someone, whatever the cost.

However, most groups that people join do not give them what they really are seeking. This is a sobering thought for group services. Group services today do not provide psyche groups, by and large. Staff personnel are, in fact, unable to provide what is being sought by the people who come to them and, more important, by those who do not. Groups in our agencies are less likely to answer the need of individuals to be wanted and accepted than is the street gang, for instance. They are less likely to be replacements for the family life people quest, or the friends they never had. Where can one belong where one is wanted just as one is? What acceptance lies behind the avowed purpose to change individuals? What is the reaction of our members when the implication is that we look upon them to change them instead of to serve them?

One obvious implication is that in order to be accepted they must change, which may mean conform. The middle-class mother, for instance, says, "Mary, don't do that or Mother won't love you" —teaching conformity and the notion that love and acceptance come at a price, the surrender of autonomy. This is the basis of the self-image and the role concepts that will be discussed later. To do as others require is a value in our society, and it has become a value in our group services. Much that is published in group dynamics seems to be based upon conformity and consensus as a value toward which the group strives.

This is the basis of some of our emerging theories of psychotherapy and group psychotherapy. In group psychotherapy the therapist seeks to develop transference to the group and its members rather than to himself as the adult or authority; but always the striving of the individual is for unconditional acceptance which seems to come, if at all, by conforming.

Basically, we and our children are different only in degree from gang members and the organization man. We are all seeking the same things but choosing different ways for achieving them. We are as conforming and as lonely, but the primary difference lies,

I think, in the fact that some have known family life, and have internalized some ego strength and superego restraint. We all want what groups are said to give, but for the most part do not give. Normal and maladjusted people are in the same boat.

The use of diagnosis to determine need is a more valid approach to base practice on than what one must change in the individual. May we revise our approach to an older one, and a sounder one? What needs change in the individual is but a symptom. Its elimination is only one part of treatment and help. The identification of symtomatology as part of the study process is important to understanding social and personal needs. If the group services placed less emphasis on achieving change and more on meeting needs, assessed in the reality of the day, they would achieve more in the long run. We have fallen into a way of thinking in which we attempt to meet needs in order to achieve change, instead of achieving change as a result of meeting needs. Semantics? Not really. In one there is a psyche group, in the other it is socio; means and ends are in reverse order. In effect, social group work and the helping professions have become much the same as the family, task-oriented and success-dominated. This is not a question of either/or. It is a working premise that social functioning and social needs are interdependent. It becomes operative, for example, when we see that role behavior depends upon seeking favorable response in large measure. Social group workers do not give or enable favorable response merely because they want to change role behavior. Such a formulation would be mechanistic and bargaining. We must be careful that we do not use social science theory and findings as manipulative tools and that we avoid effecting change in social functioning while ignoring causation. Other symtomatology will develop.

Moreover, to give favorable response merely because they want to change behavior is a conditional giving and hence leaves members dependent, divested of autonomy, and emotionally unsatisfied. It makes for conformity and for a weakening of inner-directed or value-directed behavior.

We do need to be systematic in our approach to practice, but this

does not mean we should be intellectually alone. It is possible to become so scientific that the human goals and values for which we work are forgotten or displaced. This is a danger inherent in helping; it can lose sight of self-actualization, self-determination, and of the importance of motivation and the real goals of the member. It can confuse the client's real goals with his methods, his behavior, or his verbalizations.

Some questions for the leisure-time services are:

What services are being offered to help communities become neighborhoods, and families to be functioning families?

What kinds of groups and atmospheres are fostered in the group services and to what ends?

Bureaucracy has influenced social welfare services so that in many instances they have become institutionalized to the point of being inappropriate or not accommodated. Group services have been caught in cultural lag, and in general can be accused of operating on goal orientations and program structures that are not wholly suitable or precisely attuned to the social needs of today and tomorrow. Instances of such lag are: group services to the aged; family life education; community group work; service to the adolescent in specific respect to establishing norms and identity and providing status; the hard to serve; the realistic progression in sequential stages to achieve adult behavior; intergroup relations; and the provision of social welfare service for those who can afford to pay. Our fee structures are not realistic for today's situation.

Group services, it is said, need to reduce platitudes and outmoded patterns to specific goals based on reality. I am not suggesting that the role of the social agency is always to study and accommodate itself to changing trends. There is the evaluative responsibility which leads to a moral role to create trends and to influence trends within the social work value system. Social workers should be practitioners in effecting social change.

In *Dynamics of Planned Change,* the authors state: "We were dismayed by the large number of cases we encountered in which the change agent was not explicit in stating what he wanted to

change and how he expected his help to function in the change process." [2] This seems to obtain because there is a willingness to rely upon "goodness" that is inherent in our activities or services without being clear about specific aims. Boards often feel that anything done with good motive is good, and rely faithfully on the methods employed by staff. Staff often rely upon methods and activities without clarity as to the desired outcomes for their efforts.

Our agencies do have stated objectives, but they can become static and inflexible, and also be so general as to mean little. They can be so trite as to gain acceptance from all but give no direction to guide and control the operation. Goals are the determinants of planned experiences. They define the content of program and also the selection of method. They must be kept close to the reality of the present and future of the persons in the situations in which people are. Objectives give the specifications for growth and the requirements for plans, resources, and methods. There can be little hope to meet individual needs through group services if objectives are not meshed with method and content of program.

The basic factor in determination of goals is the value system upon which the sponsoring group operates. When the early settlers moved westward they found among the Plains Indians that the best that could be said to praise a man was that he stole the horse of another. One did not kill a man to defeat him. One pushed him off his horse and rode away with it. By the time the settlers had reached the West the worst that one could say of a man was that he had stolen the horse of another, and if found he was strung up to the nearest tree. In one culture the value of a horse is greater than the life of a man; in another, the life of a man is paramount. This is not a question of logic or scientific validation. Values are what one cares about, desires, really wants, works for. They are the sum of things worth living for, an ideal of what ought to be.

A lack of useful and current goals may represent a willingness to waste human resources rather than to spend material resources.

[2] Ronald Lippit, Jeanne Watson, and Bruce Westley, *The Dynamics of Planned Change* (New York: Harcourt, Brace & Co., 1958), p. 65.

On the other hand, it may be due to rigidity in organization and structure and hence resistance to innovation and change, or it may be a phenomenon of goal displacement.

An important factor in the determination of goals and services is the availability to policy-makers of information. Those responsible for the development of goals and services may have the value orientation but lack the information necessary to implement it. Lindeman made the point on several occasions that it is not the prerogative of the professional to usurp the goal-making, decision-making function of the lay community but that it is his role to see to it that all appropriate information is available to it. Without information concerning social trends, social change, and new manifestations of social need, lay persons may fail to play their roles effectively. Even more significant is that the social worker is a social statesman and should offer leadership in values. Lindeman said that social workers and social work must be supremely concerned with people and things as they *ought* to be. Newstetter told the conference some years ago that:

> There is no point in helping people to make decisions which represent a pooling of ignorance. Provision for decision-making is a hollow mockery without an adequate basis for that decision-making. Social work practice is a hollow mockery if it is not coupled with professional responsibility to help people to see the oughts that the social competence and experience of the particular practitioner and agency can afford.

If many group services have failed to address themselves to current needs in meaningful ways or have neglected to keep up to date; if they are serving communities that no longer exist; and if some are ignoring the poignant social needs in our ever changing social scene, it is not directly attributable to the conservatism, stubborness, or stupidity of lay boards. I suggest that it probably reflects the bureaucratization of the social welfare services which are unwilling often to give up services or stereotypes, which often have resisted the implication of community study and diagnosis, which have been unable to change perspectives from their own tradition or orientation, and which may be unknowingly and sub-

tly maintaining the status quo. In other instances, it may reflect a weakness of not working closely and effectively with boards and communities.

Goal-setting and reassessment of service is an ongoing process. It is not enough to want to update practice, or to say that you do. It calls for rethinking concepts and for alteration in mind sets.

Goals are translated best into services through a systematic attempt to think of objectives, methods, and content of program together. This implies that in any plan all three must be explicit for each of the three; that is, every objective must have its methods and content spelled out, and every activity its objectives and methods matched to it, and so on. In addition to the program activities, there would be an assessment of the potentials for growth and education for individuals in all the experiences within the services. Program should be conceived of as the total set of experiences the individual has through the service. All the situations can be learning situations if so viewed and used.

The setting of goals and functions results from study and review by lay committees, with guidance from staff. However, professional staff need to do intensive study of the social scene, the values of social work, and the potentialities of program. Staff commitment must be strengthened and developed or there will be little institutional change. The most effective way to arrive at such commitment is through staff study and meditation, with complete sanction of board and executive. Committees of board and staff members can work and plan together, but staff must continue to refresh and train itself in new methods, new knowledge, and periodically check its eyesight and eyeglasses through reading and conducting seminars on the changing character of communities and their social needs. To be useful, this perpetual inventory must be shared with volunteers, part-time workers, and peers.

The hardest part seems to be to give up pieces of program and methods so as to make room for newer units and approaches. In this regard, the agency becomes a reference group which anchors to a set of norms, and hence, one must work with the total structure to effect change in its parts. Where a professional association is moving forward and workers identify with it, or with a dynamic

social planning council, changing perspectives are easier to achieve.

We can now turn our attention to some of the ways in which group services can help individuals to achieve change, with the understanding that these methods are not used mechanically but as part of meeting individual and group needs.

Program.—Selection of programs, activities, or experiences is the skill and the art of the group worker. Our knowledge in these areas has increased considerably in recent years. We know now, due to the initial work of Paul Gump [3] and others, that activities have different potentials for facilitating interaction, for increasing communication, and for various dimensions of need of satisfaction. Using Gump's studies, Crawford [4] has developed a rough typology of agency activities. More recently, Robert V. Vinter [5] has adapted these principles to the program of the group services' agency. Today it is possible for staff to fashion a program with reasonable confidence in selected predictive values based upon study and diagnosis. We have, for example, prescriptions developed for many games, their potentials for growth, scales for their structural properties so that rules can be ordered and planned in progressive sequences of rigidity or permissiveness, the milieu can be assessed for anxiety production or hedonic tone, the rules can be determined for degree of risk involved, opportunity for creativity and self-actualization can be judged, and so on. Even though it is still crude, we have in the differential selection of games and the adaptation of use, an instrument that is sensitive to a vast range of goal potential. We also have less fully developed prescriptions for other activities.

We know that each activity may not be of benefit to every member in a group, but we are in a position to avoid using programs that might have negative results for the groups or any one member.

Self-image.—Individual change may be conceptualized in many

[3] Paul V. Gump, "The Ingredients of Games and Their Impact upon Players" (Wayne University School of Social Work, 1955; mimeographed).

[4] Jean N. Crawford, "Impact of Activities on Participant Behavior of Children" (Master's thesis, School of Social Work, University of Michigan, 1957).

[5] Robert V. Vinter, "Program Activities: an Analysis of Their Effects on Participant Behavior" (School of Social Work, University of Michigan, 1959; mimeographed).

ways. At this stage of our knowledge, the concept of self-image is a useful one. The way a person behaves is tied closely to the image he holds of himself. His image includes the kind of person he thinks he is, the skills that he has, and how he thinks other people regard him. Self-image grows out of responses of others which become internalized.

Persons tend to compare the image that they have of self with what they regard as normal and ideal. If one is optimistic and thinks of himself as up to what is normally expected for age, sex, position, and culture, he will be able to risk, socialize, and learn. If, on the other hand, he feels inadequate as matched against what he regards as normal or ideal, he may try to avoid risk, or to overrisk, and may seek satisfaction in deviant behavior.

The way one perceives oneself is an indication of adjustment and can be a strong determinant of behavior. It is unlikely that behavior can be changed to any significant extent without concomitant changes in self-image. The image may be realistic; that is, it may be the result of an inability to gain favorable response from others. This may be due to an inability to assess the social demands made of him, or to a lack of capacity or skill in complying, or to the position he occupies in any social context. The image may be unrealistic due to personal distortions based upon need, or due to lack of sensitivity to the cues put out by others. The factors then are ability to perceive norms, expectations or demands, skill to perform, and personal psychic balance to function within social demand.

Since self-image develops within interpersonal interaction, it may also be changed within the same context. We are dealing here with a group concept. Change in behavior can be achieved through learning how to read expectations correctly, learning skills, and through acceptance gained through social achievement. When one has esteem of others, his regard for himself and others increases. Confidence in oneself leads to confidence in others and hence to enhancing relationships. As a corollary, it is doubtful that one will engage freely in behavior likely to threaten one's self-image.

Any agency activity, climate, or demand may be conclusive to self-knowledge and self-confidence, as well as to increased skills in

this context. However, if this is a goal, the way in which agencies offer and use services becomes crucial.

It seems axiomatic that lack of acceptance in any group or milieu will result in a rejection of the values of that group or milieu.

Reference group theory.—Attitudes, values, and norms have their major source in reference groups. Reference groups also provide a major anchorage in self-identity. Self-attitudes, social roles, and social behavior are learned in reference groups. Their standards become internalized as parts of the superego. It might be postulated that aspects of the developmental tasks, such as autonomy, identity, integrity, and so forth, are achieved or distorted in groups. It is important, then, to know whose favorable response an individual seeks if one is to understand behavioral change or resistance.

When an individual who is strongly identified with one group is participating as an announced member in actual face-to-face interaction in another group, his change or conformity will be deflected in terms of his anchorages in his reference group, and his self-concepts. The greatest scope and degree of change come with change of reference group rather than by single exposures or stimuli.

Newcomb's Bennington study demonstrated that a large social unit, a college in this instance, can become a reference group and affect the values of its members. In principle, agencies and groups within them should strive to become reference groups to client members and also to staff members. A reference group expects devotion from its members, and it also gives devotion. This is a significant notion in examining our practice. There is a difference between a reference group and a membership group. It is wholly possible to be a member of a group and to conform without experiencing any concomitant effect. It may be said that any change in individual behavior involves a change to another reference group, a change in the reference group, or a change in one's position and status in the reference group.

Change in role.—Role theory is one of the newer and more important contributions to the conceptualizations of human behavior, and it is most applicable to group services. A role is a pattern

of expected behavior associated with a certain position and status. Role enactment and expectation are reciprocal and hence interactive in nature. Role behavior is learned behavior. It is learned in groups and becomes internalized through favorable response, identification, and socialization. Each individual learns some sets of behavior in preference to others. There is a wide latitude for choice in role selection. However, there are social demands, and compliance is based upon behaving in accepted ways for the positions that persons occupy. Failure to behave as expected, as in the case of self-image, may be caused by faulty perception or poor skills. A new dimension of interaction must be added here to make the concept dynamic. This is the interaction of self and role. Each person enacts roles through personal motivation to meet needs and drives, and no matter how much one's goals are influenced by others, each person behaves in accordance with his own personal goals and each is impelled to achieve a desired object in his own special way.

Group services may be instrumental in bringing about individual change through reorienting role expectation, teaching role behavior, and affecting attitudes and values that motivate role behavior. Activities and experiences can be designed to provide conscious role reeducation so that individuals can perform, gain rewards for changed role behavior, and gain satisfaction of needs resulting in more favorable responses from others.

This phase of behavioral change requires, of necessity, careful study of behavioral goals and appropriate behaviors within given cultural contexts for age, sex, and specific positions. It is not necessary for each board and staff to begin to devise such goals without some help. Russell Sage Foundation has published *Behavioral Goals of General Education in High School,*[6] for example. A committee of social workers in Pittsburgh reviewed the book and agreed that these were the goals of group services also. *Designing Education in Values*[7] by Sorenson and Dimock is an excellent

[6] Will French, *Behavioral Goals of General Education in High School* (New York: Russell Sage Foundation, 1957).

[7] Roy Sorenson and Hedley S. Dimock, *Designing Education in Values* (New York: Association Press, 1955).

guide for developing specific objectives for value change and role education.

The worker.—Behavioral change can occur through direct teaching, incidental learning, and identification. Our attention may well be drawn to the question of role models. What are the criteria for selection of volunteers and part-time personnel in group services? If our expectation is that they will influence role behavior, what are their identifications, their value orientation, and the awareness of role prescriptions? The character of an agency, like that of a community, is reflected in the roles which it accepts or rejects. There is no clear picture today of the expectation of the behavior of the worker. I believe that method is second in importance to the values and behaviors of the workers in the way method is employed. As Margaret Mead has pointed out, whether the disciplinary method used is cajoling, beating, or rewarding, little Indians grow to be big Indians. They grow up to be like the significant others in their lives.

So it is also that the total service has it influence: the philosophy and value system, the structure and atmosphere, the administration of the services, how the program is offered, the rewards given, and the methods. These are important variants along with the status that the worker earns in the groups, the status the service enjoys in the culture, and the perceptions that the members have of the role of a helping person. It is doubtful that a helping person can achieve much success, for example, if he himself fails to gauge the expectations that members have of, and for, his position and status.

For change to evolve, the agency must support the change. The worker will not only set up environments and situations to facilitate learning but will stand by during the struggle to be ready to help. The agency begins by creating the climate that says that it believes that change is possible and that it has every confidence that the individual will be successful. In addition, it will provide methods for getting support for the change in the larger milieu, that is, in families, communities, reference groups, and so on. It would seem to be a theorem that there must be an accepting cli-

mate for any change in desired directions to eventuate. Nonaccepting climates, by threatening the individual, intensify resistance, strengthen defenses, and retard the security needed to allow risk. The fact that a small group may have an accepting climate is no assurance that it exists in the agency or over-all services.

Personality change.—Group services are directed primarily to enhancement of social functioning. Personality structure limits the range of possible behavior, but it does not prescribe precisely how one must act. Every personality has many alternate ways in which to express itself in any situation. It is much more likely that group services can produce changes in behavior than that they can produce much change in psychic structure. Saul Scheidlinger has reported that in experiments at the Jewish Board of Guardians in New York, considerable change was effected in the behavior of boys in groups which carried over into school and home, but no concomitant change in basic personality was discernible at the same time in personality or attitude test scores. There is reason to believe that behavior can be changed before values or attitudes and that once changed, though a theory of consistence, attitudes follow. However, must stabilization of change rest upon personality change? My hypothesis is that one can change self-image and role behavior without change in psychic structure.

It is my contention here that group services can change behavior. If behavior is a function of the interaction of personality and environment, behavior will change if there is a change in social environment. Personality can be viewed as constant. This phenomena occurs through ego selection; since the ego has a wide range of choice, any need or combination of needs may be manifested in various behaviors.

If X. changes his approach to Y., Y.'s response may well change. Since Y. is part of X.'s social environment, that environment has now changed and will effect still further change in role behavior, even without altering personality. Behavioral changes set up a dynamic movement in all parts of the formulation. Assume that the social environment continues to change in response to changed behavior; we can predict a change in self. This sequence may lead

to a personality change. But is personality change inevitable or is it even the core of change in group services? I suggest that it is not and that our primary emphasis is on changes in behavior. That is the core of group practice and the basis for enhanced social functioning.

This is no refutation of the value of group services in personality development as distinguished from change. Nothing stated in this discussion is a contradiction of personality theory usually associated with social work. The superego is the internalized value system of the environment; the ego seeks to keep in touch with reality in order to satisfy the id with the limits of a social and physical environment. My thesis is not based upon a behavioristic theory of personality but upon that aspect of ego psychology which is within the function and competence of group services.

Group factors.—Recently we have become more aware of the importance of goal orientation based upon standards for achievement. Group services can help to develop models by being explicit about what a "good" group does, as well as a "good" group member or president. How clear are we ourselves when we talk about a "good" club? Transmission of a standard helps the members to know against what to measure their behaviors and achievements.

In this relation there is a growing tendency to accept the idea that if one is to help an individual change behavior he must have a new perspective on behavior; that is, he must be able to visualize the new or alternate possibilities. Part of this process is the mirror of present behavior and changes as they occur.

It is only recently that we have become aware of the positive relationship among goal felicitation, hedonic tone, the ability of a group to work together, and cohesion. There is good reason to believe that group services have more chance of effecting positive change on individuals if the groups have goals and work toward them, and the individuals have ego commitment to them. This has given rise to the idea of group curricula and has led some theorists to suggest that groups that are successfully involved in meaningful tasks are effective in bringing about desirable change in individuals. At the same time, one ponders the effect of the well-

known principle that once groups institutionalize their norms and structure, power members work to prevent modification of the status quo. As a unit of service, the well-knit friendship group may not be the most effective medium for change in many instances.

Of immediate significance is the structure of the group. Perhaps the most easily observed aspect is the power relationships. The concepts are position, status, and role. Status persons are able to influence change in group functioning within the limits of a group's range of expectations for such status persons. Status may be changed by changes in group goals, an individual's performance in a valued status-giving skill, a change in the value system, the influence of the worker, and by contagion from higher powered persons. Since attitudes and self-images follow roles, changes in positions and status will alter the attitudes and behaviors of individuals.

On this point, Seymour Lieberman, reporting on an interesting piece of research, states that people who occupy a role tend to acquire a set of attitudes which are consistent with the expectation of that role. As the position changes, the attitudes go along with it.[8]

There is another interesting dynamic that group services need to examine more fully, namely, access to information of importance to the group confers status. Popular persons have more status than unpopular ones usually. Status confers privileges, such as access to more information, access to resources, and even access to leadership and the worker. The acquisition of these privileges results in control, insight, and the ability better to judge the opinions in the group. Such power thereby confers greater status and leadership. The unpopular persons tend to have less information and are forced more and more into peripheral positions and lower status. Gordon Hearn [9] demonstrated that such dynamics operate in a board. They also apply in a staff and other groups in agencies.

Those who like one another communicate with each other. By

[8] Seymour Lieberman, "The Effects of Changes in Roles on Attitudes of Role Occupant," *Human Relations*, IX (1956), 385–402.

[9] Gordon Hearn, George Williams, "The Decision-Making Process in Voluntary Agency Boards of Directors," College *Bulletin*, No. 3 (April, 1954), p. 1.

so doing, they also restrict communication to and from the less popular one. Soon status is divorced from any skill or attribute. Power begets power and also the resources for personal growth and development. The contributions of the less popular tend to be disregarded.

One notes that frequent speakers and actors are more frequently addressed and interacted with. They speak to, and interact favorably with, each other, reinforcing power, status, self-images, and roles. Restricted communication is characteristic of such structures. This structure delays transmission of information to new members and delays their introduction and use to the group. It will probably encourage change in many persons in directions that are diametrical to what might be desirable.

Consciousness of high status improves an individual's performance, and others perceive the value of that performance as higher. The same obtains in reverse; that is, low status reduces the quality of performance and the perception of its value. Social skill, therefore, is socially determined to a large extent.

It follows that were all people alike, differences in behavior could be accounted for by position. It follows also that behavior can be affected by change in position. How one is able to satisfy need is controlled by position to a great degree. Peripheral positions encourage withdrawal and hostility. To be under the control of others is frustrating to many and affects one's sense of security, adequacy, morale, autonomy, and can result in apathy or aggression. It may result also in neurotic symptoms.

Where communication is improved and access to information and resources spread, there will be greater adjustment and hence improved social functioning. Within these principles, as limited as our knowledge is, we can see that agency structure and the entire operation of group services play a tremendous part in achieving individual change. Blocked communication from community to board, board to staff, staff to clientele, can have dire consequences to any one individual in the total configuration.

Group services can be analyzed in such terms as: facilitation of communication and interaction; shared access to need-meeting re-

sources, such as activities, persons, information, positions, status, and roles. All these factors can be used consciously to bring about change in social environment and in individual functioning.

We can be somewhat certain about the negatives in the picture. There will be no change if:

1. The present influences remain the same.
2. The rewards for remaining unchanged are greater than those offered by change.
3. The risks involved in change are too great.
4. Anticipations of being responded to by others affect negatively one's own evaluation of self or are attached to one's idea of one's status.
5. One's defenses are being attacked or weakened.
6. There is no prestige in the change, or at least no perceived satisfaction.
7. There is a threat to one's self-image.
8. Ego involvement in the status quo is great.
9. The individual is rejected by the worker, the agency, or the socially desired group in the agency.

The major theme of this discussion is that achieving change in individuals through group services must be conceived of as a planned process; that generalized, normative, and intuitional programing leaves much to be desired. Steps in planned change may be summarized in Lippit, Watson, and Westley's [10] terms:

1. Diagnosing the nature of the problem
2. Assessing the motivations and capacities to change
3. Appraising our own motivations and resources
4. Selecting appropriate change objectives
5. Choosing an appropriate type of helping role
6. Establishing and maintaining the helping relationship
7. Recognizing and guiding the phases in the change process
8. Choosing the specific techniques and modes of behavior which will be appropriate to each progressive encounter in the change relationship
9. Contributing to the development of the basic skills and theories of the profession

[10] Lippit, Watson, and Westley, *op. cit.*

If these are basic and generic to planned change in all the helping professions, what is it that makes the contribution of group services unique? It is the skillful and conscious blending of our social work values with the disciplined, knowledgeable use of the social processes, and the professional selection of methods and techniques for the achievement of clearly defined social goals, based upon conscientious study and diagnosis.

The group is the major source for satisfying basic social needs and the chief influence on values, attitudes, and conduct from latency on. It is the place where patterns of social conduct are learned and reinforced through practice. It is neither unreasonable nor immodest to suggest that group services are one of the most potent social services in helping individuals to achieve change if they are offered attractively and are designed specifically for that purpose.

Medical Care Issues in the United States

by HERMAN M. and ANNE R. SOMERS

MEDICAL CARE IS NOW IN THE FOREFRONT of public policy discussion. More articulate concern is being devoted to medical care questions within the profession and by the public at large than ever before. Significant numbers of people believe that they lack effective access to the medical care they need or may need; and significant numbers of doctors and other professional personnel believe that they cannot or do not provide the amount and quality of medical care which are scientifically and technically feasible and desirable.

On the surface it would appear an amazing paradox that such issues should push forward at the present time, when medical practice is based more firmly than ever on scientific knowledge, medical care is a much better product, and more people are receiving competent care than ever before in our history. Yet, simultaneously, there is growing uneasiness, increasing discontent, and a greater sense of insecurity regarding the situation on the part of patients, doctors, hospitals, insurance carriers, and the public at large. As is frequently the case, the progress and the difficulties are reverse sides of the same coin. In social life, as in science, history shows that every partial solution to a problem, every surge forward, promptly explodes open a new set of problems, some more serious and more complex than those which preceded. We are at the same time both beneficiaries and victims of our own progress.

To understand the complex issues we are dealing with and thus to distinguish possible paths to solutions we must try to identify

the large trends in both the professional and the consumer aspects of medical care. There are three major historical developments: first, the changing character of the medical product and the techniques through which it is produced—what the economists would call the supply of medical care; second, the altered nature of the need and the demand for the medical product; third, the recent attempts to resolve maladjustments in supply and demand by changes in the mechanics of the medical market place.

We start with the supply of medical care. Every literate person is aware of the amazing achievements of what may be called the scientific revolution in medicine: the recent advances in brain and heart surgery, anesthesiology, chemotherapy; the continuous progress in diagnostic procedures and instruments, in endocrinology, and in the treatment of the mentally and emotionally ill. In the past decade we have witnessed a revolutionary break-through into a whole new area of medical science—viral disease—and the development of a reasonably effective antipolio serum which could lead eventually to the conquest of viral infections.

As a result of such progress, the United States death rate has been cut in half since the beginning of the century. Life expectancy at birth has increased from forty-seven to seventy years. In half a century almost twenty-five years have been added to our lives. A sometimes overlooked result, of special interest to social workers, is that the duration of an average marriage—before one of the partners dies—has lengthened thirteen years, and thus the social problem of orphanhood has virtually disappeared.

The remarkable progress in medical science is generally well known. Less obvious is the fact that the scientific developments have resulted in a vast change in the technology of medical practice. The provision of medical care has been transformed from an individual profession into a highly organized and institutionalized industry encompassing a vast army of over two million workers, growing far more rapidly than other leading industries. Within the great over-all growth, perhaps the most striking fact is the extent to which physicians' services are more and more augmented by those of other health personnel. The ratio of doctors to all health service workers is now roughly 1 to 10. These others now

include about twelve thousand social workers whose important role is steadily receiving increased recognition.

Parenthetically, it should be pointed out that the employment of social workers is rising primarily in the pace-setting institutions, those which are building the future. For example, at the new University of California outpatient clinic in Los Angeles, the Department of Preventive Medicine operates a seventeen-man social department, not only to deal with patient problems, but also to instruct medical students in problems of comprehensive care. At the other end of the country, Montefiore in New York City, admittedly one of the nation's most adventurous hospitals, is involved in an experiment in family health maintenance. The heart of it is the creation of a three-man team—physician, public health nurse, and social worker—to substitute for the traditional family doctor. It is safe to predict that social workers will become a large and more significant sector of the health services professions as time goes on.

The technological response to science has made available medical tools, techniques, facilities, and aids unheard of fifty years ago. But technology, like Aladdin's genie, is tyrant as well as servant. It dictates professional structure as well as the character of care. Specialization is inescapable with the expansion of a profession's total knowledge and variety of skills. The ratio of full-time specialists to all physicians has quadrupled in a mere twenty-five years, at the same time that general practitioners have declined 22 percent. In 1957, almost half of all doctors in private practice reported themselves as full-time specialists.

The myriad advances in science and technology which have led to specialization have also created interdependence in the profession. Cooperative arrangements among doctors are now virtually universal. A wide variety of "group practice" and "combination practice" organizations have developed, including partnerships of many kinds; private clinics; hospital groups; industrial groups sponsored by labor, management, or both; and consumer-sponsored groups. As already indicated, the doctor has become highly dependent upon squadrons of aides, nurses, chemists, laboratory technicians, therapists, medical social workers, and many others.

The effective doctor is now the center of a large team organization. A lone physician with the facilities of one office can no longer render adequate medical care. The necessary knowledge and skill are beyond one person's capacity.

The same forces have caused a tremendous advance in the extent and character of hospital utilization. The hospital has become the core of the medical world. "Within living memory an age-old institution has been transformed from a hostel for sick-poor into a medical center for everyone." [1] In the modern hospital or medical center a vast number of interdisciplinary skills are brought together for research, education, and treatment in recognition of the new character of medical care, which calls upon and affects the whole of a community's resources. For example, at the New York Medical College–Metropolitan Hospital Center, a medical-surgical committee of forty to sixty persons will confer on diagnosis in difficult cases. The program for each patient is decided upon by the group. Working teams of physicians treat patients with follow-up through their recovery.

Even in the inner confines of the hospital operating room, the necessity for interdisciplinary cooperation has become prominent. The team which is experimenting with surgical control of cerebral palsey at Mt. Zion Hospital, in San Francisco, includes a biophysicist, an engineer, two neurosurgeons, a neurophysiologist, a speech pathologist, and a psychiatrist.

Such technical and organizational developments have made possible the translation of scientific advance into actual practice. The efficiency and productivity of all major components of the medical service industry have increased markedly. The average length of stay in short-term hospitals has been cut in half in the last twenty years. With the shift in the primary locus of practice from home to office, clinic, or hospital, the average doctor is able to see many more patients than before—a weekly increase of nearly one third in the past eight years. Lifesaving drugs, like penicillin, are now mass produced at prices which are—or could be—within the reach of nearly everyone.

But there is a tragic "other side" to this efficiency. For one thing,

[1] Michael Davis, *Medical Care for Tomorrow* (New York: Harper, 1955), p. 111.

just as medical science has established the overwhelming importance of psychosomatic factors in illness, just when medicine has advanced to a point where the much heralded patient-doctor relationship can really take on some scientific significance in addition to the sentimental values of the past, the ever increasing time pressures hardly permit the doctor an exchange of decent amenities with the patient.

It is clear to many leading physicians that symptomatic medicine, which is currently so widely practiced, and the increasing reliance on chemotherapy are not really reaching the basic cause of illness in many cases and are particularly inappropriate for long-term chronic illness, which now represents such a large portion of our nation's total morbidity.

Second, the greater complexity of the medical product has inevitably made it far more expensive. Additional personnel, more facilities, more mechanical equipment, improved medication—all these cost money. It is not entirely surprising that medical care prices have risen over the past decade about twice as rapidly as the general price level; hospital rates, about five times as fast. Equally important, prices are an incomplete index of cost. We are using far more medical services than in the past. The relative importance of medical care in the average family budget has risen about 60 percent in ten years. Put another way, we spent twice as many dollars for medical care in 1957 as in 1948. About half this increase represented price inflation; the other half represented a real rise in the medical goods and services utilized.

Blue Cross of Philadelphia reported in 1958 that it had paid a bill of $10,356 for a seventy-day hospital stay for a thirty-three-year-old woman. Included was a payment of $9,000 for drugs, mainly cerrocillin, a special type of penicillin. Two decades ago, such a case would not have cost much. The drug was unavailable; the patient would probably have died. Today, the lady is happily alive, but a $10,000 bill for a lower-middle-class family has to be paid. The Philadelphia Blue Cross has about 268 cases a month in which costs run to over $1,000 apiece.

The reduction in the average length of stay in hospitals is more than counterbalanced by the additional utilization and the greater

number of admissions, as well as by the higher prices. Moreover, it appears that we are gradually approaching the limits of feasible reduction in length of stay. California, already well below the national average, may have almost reached that point. The next goal may be recognition that some conventional types of hospitalization can be wholly eliminated.

In the Los Angeles area, for example, the costs of hospital services associated with a tonsillectomy range from about $140 to 0. The zero is for patients of the Ross-Loos clinic where such surgery is done in the clinic on an outpatient basis—with excellent results. Of course, as a practical matter such lowering of hospitalization costs can only be accomplished where comprehensive outpatient services are covered by insurance as opposed to the conventional hospital-surgical contract—an illustration of the fact that control of medical costs is related to the need for some basic changes in the insurance structure. But we are ahead of our story.

The price of physicians' services has not risen nearly so much as the price of hospital care. But this is misleading for several reasons. We use physicians far more frequently than we used to with proportional increase in cost. And payment to the family doctor is no longer a valid index of medical costs.

A year ago, a friend of ours took a set of disturbing symptoms to his family physician, a conscientious general practitioner whose facilities and equipment are not adequate to deal with any but the most conventional ailments. Our friend was therefore referred to a Philadelphia diagnostic clinic for a series of tests which a general practitioner cannot perform: standard cost, $175. The tests were negative. As a result, psychotherapy was indicated, and he is now undertaking such treatment at a cost of $200 a month. Both of these bills, staggering for a teacher, represent relatively new types of costs. Incidentally, while the institution where he works furnishes major medical insurance coverage, neither of these costs is covered because the scheme, like many such policies, specifically excludes diagnostic examination and psychotherapy from coverage.

Compared to its predecessors, the new medical product is as a new Cadillac to an old Model T. It is bigger and better, and far more costly. But unlike the Cadillac, which most of us can do with-

out and not suffer any acute sense of deprivation, modern medical care is essential.

A great number of physicians are earnestly trying to keep the organization and price of medical care in reasonable accord with the demands of science and the income of their patients. As already indicated, we are witnessing a tremendous drama of experimentation with revolutionary implications. But we must not be misled by the vanguards. Medical practice is still, by and large, organized in a relatively obsolete manner. The medical profession is conspicuously suffering from the maladjustments between conventional structure and the dictates of technology. The air is frequently pierced with cries of anguish from many sectors of the profession at being pulled, pushed, and dragged out of habitual patterns into the unfamiliar present.

The resistance is human and in no way surprising. Transitions are always marked by maladjustment and resentment. Note we make no invidious reference to "vested interests." John Kenneth Galbraith said in *The Affluent Society* that a vested interest is "an improper advantage enjoyed by a political minority to which the speaker himself does not belong. When the speaker himself enjoys it, it ceases to be a vested interest and becomes a hard-won reward. When a vested interest is enjoyed not by a minority but by a majority, it is a human right." [2]

Rather than deplore the doctors' current economic advantage (it is reported that today the average physician has a net income of about $22,000), we prefer to root for the extension of this pleasant condition to members of other professions, including college professors and social workers, who, we understand, are not quite netting $22,000 a year—and perhaps that fact helps explain their greater receptivity to change!

But again, this would be an oversimplification. As Galbraith has also made clear, the vested interests of the mind are at least as important an obstruction to innovation and change as the vested interests of the purse.

In any case, the point is that the tendency of medical organiza-

[2] John Kenneth Galbraith, *The Affluent Society* (Boston: Houghton Mifflin Co., 1958), p. 181.

tion to lag behind scientific and technical developments jeopardizes the quality of medical care and threatens our capacity to bring the advantages of modern medical technology to the populace through insurance or other mechanisms.

Now to our second basic factor: the changes in the character of need and demand. These are made up of two major components: (1) changes in basic demographic and morbidity patterns; and (2) changes in the social structure and social attitudes.

The remarkable increase in longevity has resulted in marked changes in the incidence and pattern of illness. The proportion of those sixty-five and over in the population has more than doubled since the beginning of the century and the trend is still upward. It is hardly surprising that people over sixty-five have more episodes of illness and more days of disability than younger people. As a result, they require far more extensive use of medical resources at a time when they are relatively least able to pay for them. For example, the aged average over twice as many days in the hospital as the general population. As a result, we face increasing medical dependency.

Dr. Lansing, president of the Gerontological Society, made dramatic the paradox of medical advance without commensurate social advance in this area when he recently said that the elimination of cancer, heart disease, and hardening of the arteries "could easily constitute a major disaster in this country."

The resultant problems are not confined to the aged. As we preserve life at all age levels, there is more illness, more enduring disability for the population as a whole. Especially noticeable is the vast increase in chronic illness. The control of many erstwhile fatal diseases, like diabetes, and disabilities like spinal paralysis brings about the need for expensive lifetime medical supervision.

Similarly, as we proceed with the successful conquest of physical disease, we become more aware of the interrelationship between physiological and mental illness. The extent to which there may be more mental illness now than before is not known. But it is clear that illness of this nature which once was not recognized or not understood, and thus not treated, now consumes a major por-

tion of our medical resources. Nearly half of the hospital beds in the country are occupied by the mentally ill.

The corollary of these shifts is a growing need for long-term, preventive, rehabilitative, semicustodial, and medical social services. Most chronic diseases are months or years in developing and require early diagnosis if they are to be handled effectively. The period of treatment is extensive. If "cure" is achieved there is often required a long postcure rehabilitation. Thus we witness an enlargement of the concept of "adequate medical care" to include a broad spectrum of services running from earliest positive promotion of health to ultimate rehabilitation.

And so we have the great paradox: the spectacular advances in medical science and technology have actually contributed to a rapid increase in the need and demand for medical care. Today's problems are in large measure concomitants of yesterday's triumphs.

The second aspect of demand relates to the change in popular attitudes toward medicine. This stems both from the changing intellectual and political climate of the country, with its increasing emphasis on the value of the individual, and from increasing familiarity with the medical potential. We sometimes tend to forget that the essentiality of medical care is a very recent phenomenon. An oft-repeated statement, attributed to Dr. Lawrence J. Henderson of Harvard, still provides needed perspective: "I think it was about the year 1910 or 1912 when it became possible to say of the United States that a random patient with a random disease consulting a doctor chosen at random stood better than a 50-50 chance of benefiting from the encounter."

In short, the great achievements to which we have referred have largely taken place within our lifetime. In 1900, the availability or nonavailability of the run-of-the-mill medical care of that day did not make a vast difference. Only recently has it acquired the power to give or to withhold life, to give or to withhold the functional capacity which may determine the value of life. Men are now aware that the degree of accessibility or nonaccessibility of modern medical care is a demonstrably crucial factor in personal and national welfare. This has profoundly affected both individual and community attitudes towards the product.

As a general principle, the more useful and more vital a service becomes in the social order, the more certain it is to become identified with the concept of "human rights." In 1952 the President's Commission on the Health Needs of the Nation enunciated as its first guiding principle for approaching the nation's health problem: "Access to the means for attainment and preservation of health is a basic human right." In the intervening years this has been underlined by a spread in community activities and a progressive emphasis that health and medical care are essential sources of the nation's economic, military, and moral strength. Small wonder that medical care is changing from the status of a "private luxury" or a "blessed benevolence" to that of a "civic right."

More and more, consumers are becoming organized for the purpose of giving that abstract right practical meaning. Through union health plans, industrial health and welfare funds, consumer representation of community plans, and other media, their voice is, for the first time, finding united and professional expression.

This brings us to the third major trend, the new mechanisms for reconciling and balancing the scientific revolution in medicine with the revolution of rising expectations in demand.

During the past few years there has been a dramatic change in the method of paying for health services. The proportion of the nation's total medical bill which is paid directly by consumers to their doctors or hospitals has been rapidly declining. Only a little over half is paid in this fashion now, compared to about 85 percent in 1929.

During the same period governmental expenditures for health and medical care have risen steadily. They now account for nearly a quarter of the total.

The most rapid change has been in the role of private health insurance. The increasing necessity for medical care and its rising costs made it inevitable that some new method had to be found for spreading the risk and sharing the financial burden. Health insurance, once a controversial issue, is now fully accepted in our society. In 1957 insurance expenditures accounted for 19 percent of the total medical bill as compared to less than one percent in 1929. About two thirds of all Americans have some form of health insurance.

It should be remembered, however, that these shifting relationships have taken place within the framework of a constantly expanding total, in which all three segments—private, out-of-pocket payments; private health insurance; and public expenditures—have increased greatly in absolute terms and relative to the rest of the economy. In such a context the public and private medical economies cannot be viewed as deadly rivals for a relatively fixed amount of the consumer's medical dollar. On the contrary, a persuasive case could be made for the proposition that in this, as in other areas of the economy, the growth of each has aided rather than impeded the other. The precise nature of the relationship between the public and private medical economies is still a moot issue, however.

It is almost axiomatic in American political life that government is permitted to do only what private institutions cannot or will not do. Therefore, the central question at the present time is the degree to which private health insurance can succeed in resolving the maladjustments between medicine's scientific potential and current economic and organizational barriers and thus succeed in meeting the growing demand of doctors and patients alike for more adequate care.

We are still in a period of great ferment and development in private health insurance, and it is too early for definitive evaluation. But an impressive amount of data is already available. Indeed, it has been said of us that our technical knowledge of health insurance problems and experience is only equaled by our failure to make adequate social use of it. But that phenomenon is not peculiar to this field.

Here we can only suggest a few of the more significant and summary generalizations:

1. The over-all achievements of voluntary health insurance have been spectacular. It has played a substantial role in making possible a larger amount of better medical care for more Americans than ever before in our history.

2. The greatest progress has been made with respect to over-all enrollment. About two thirds of our population now have some form of health insurance—a remarkable achievement for a private

program. The largest source has been the tremendous growth of employee health and welfare plans, to which the vast majority of enrollees owe their coverage.

We may, however, be approaching the limits of feasible enrollment. The excluded are generally characterized by self-employment, advanced age, low income, or rural residence as well as by higher-than-average medical needs and costs. Because, for the vast majority, enrollment is an attribute of employment status, because most individual policies are of a limited "term" character, and because even in group policies there is frequently a maximum money limit leading to cancellation, the protection for many enrollees may prove, at least partially, illusory.

Even more important is the distinct possibility that some of the very forces which helped to accelerate the upsurge in coverage may now impede further expansion and, possibly, even lead to some decline. The commercial carriers, who now lead the field, achieved their primacy largely through differential pricing or experience rating whereby they could pick off the better risks by offering them more favorable rates than could the community-rate plans, like Blue Cross and Kaiser.

The result is that many Blue Cross and other community carriers, squeezed between the Scylla of increasing hospital costs and the Charybdis of consumer resistance to rising rates, are being reluctantly forced to adopt experience rating, through which they too must discriminate against the aged, those with serious chronic conditions, and other "poor risks." Not only is the opportunity for additional coverage thus retarded, but members of such groups already covered may begin to be priced out of the private health insurance market. Only a reversal of the trend to experience rating could give voluntary health insurance the opportunity to provide the nongroup population or even some of the smaller groups with anything like adequate protection—or perhaps even assure maintenance of the current enrollment ratio.

There is still an opportunity for private health insurance to cover a substantial proportion of those now excluded from protection—if the over-all benefit emphasis could be shifted from hospitalized to nonhospitalized illness; if group insurance techniques

were further extended to these groups, for example, through group conversion for the retired and longer coverage for the temporarily unemployed; and if costs were better spread through wider risk-sharing. Essential to success in this respect is the curtailment of experience rating and a deliberate return to the principle of community rates.

It may be, however, that internal political impediments will make it impossible for private health insurance to succeed in covering the aged and other poor risks. If that is the case, the sooner acknowledgment is made of that limitation and means of filling the gap are found, the better private health insurance should be able to do the remainder of the job.

3. Perhaps even more crucial for the future of private health insurance is the extent of benefit coverage. Even for enrollees, health insurance in meeting only 25–30 percent of their total medical costs. Even for the 5 percent of the population which is estimated to have so-called "comprehensive" coverage the proportion of their total medical costs which is met by insurance is surprisingly low, probably less than 50 percent. As a result, enrollees and their representatives are demanding fuller protection. Health insurance itself has helped expand such demands by making people aware of what is potentially available. The rising expectations generated by experience have already made the typical hospital-surgical coverage appear grossly inadequate.

Numerous interesting experiments are in progress to cope with this deficiency. Various carriers and plans are experimenting with insurance of prescribed drugs and dental care, two of the general omissions, as well as coverage of outpatient diagnostic services and regular physicians' services in home and office. A few are working on the difficult problem of including mental illness, either by limited hospital benefits or coverage of some forms of psychotherapy.

This is a case where popular demand is consistent with good medical practice and economy. For example, the evidence is reasonably clear that nonessential and costly utilization of hospitalization is encouraged by present dominant patterns of insurance which concentrate on hospital-surgical coverage. In the absence of insurance for other types of medical bills the incentive is great for both

doctor and patient to utilize the hospital whenever possible. It might be noted that in the case of the lady whose drugs for seventy days in hospital came to over $9,000, had such drugs been prescribed for her in her home she could not have collected one penny of insurance. No matter what the actual necessities were, it seems clear that humane concern and sheer business practicality would oblige her doctor to keep her in a hospital as long as she needed medication.

The statistics show that health insurance enrollees with comprehensive coverage utilize only 60–80 percent as many hospital days as those with hospital-surgical coverage only. Comprehensive coverage, starting with outpatient physician services, would help to solve the problem of hospital insurance costs while simultaneously serving other desirable objectives, such as more prevention, rehabilitation, and home care.

4. The large majority of health insurance enrollees are covered by indemnity plans—partial cash reimbursement for services they purchase—as opposed to service plans, wherein the insurance provides for specified medical services. The distinction between these two types of insurance is vital. The fact that comprehensive direct service plans such as the Health Insurance Plan (HIP) in New York and Kaiser and Ross-Loos in California have been kept in a small minority pattern, and that many of the fine plans are gradually being forced to abandon their service characteristics, means that opportunity for taking advantage of available methods of cost and quality control, the efficiency and economies of large-scale organization, and improvements in productivity, is being largely forsaken. Indeed, the major barrier to the insurance industry's capacity to meet the demands for more comprehensive coverage lies in the fact that the preponderant idemnity pattern permits very little control over the prices charged by vendors in a scarcity market, very little control of overutilization, and no control over quality.

There are some encouraging developments, such as the increasing use of binding fee schedules and relative value schedules, and the emergence in California of the new medical society-sponsored "foundations" committed to the concepts of comprehensive service benefits and price and quality controls. Whether such advances will

be rapid enough or extensive enough to affect the threats to voluntary health insurance of incomplete enrollment, inadequate benefits, and uncontrolled costs remains to be seen.

In the meantime, government health services have been steadily enlarged. Their extension to broader categories of "poor-risk" and "high-cost" patients, diseases, and facilities seems highly probable. They are filling in the more conspicuous gaps. The ever growing dimensions and complexity of the medical care problem make it clear that we are going to need all our resources and ingenuity, both public and private.

Possible patterns of public intervention in the health field are multifold, ranging from various degrees of regulation to subsidy, to grants-in-aid, to different forms of governmental health insurance, to direct operation. All these patterns are now in existence in the mosaic of programs which constitute the public quarter of the nation's medical care bill. Our experience with such programs, including the Public Health Service, workmen's compensation, the veterans' medical programs, public assistance, Medicare, and state and local health programs, shows that public operation is not in itself a panacea any more than private operation. It should be noted that several of the conditions listed for the potential success of private health insurance would be equally applicable to public programs. Obsolete organizational structure in medicine which results in unnecessarily high costs as well as in poorer quality is a challenge to both private and public instrumentalities. So is the growing problem of chronic and mental illness. The resistance in some quarters of the medical profession, and among many consumers, to changes in medical technology and in the doctor-patient relationship would have to be overcome under either type of program.

We have demonstrated during the past twenty years that medical care is a peculiar commodity. Unlike old age or unemployment insurance, and their companion private programs—where benefits are strictly a matter of cash, unrelated to any particular goods or services—there is, in the health field, an inseparable relation between insurance or other prepayment mechanisms and the organization for supplying and pricing the product. Unlike other basic necessities—food, clothing, and shelter—where the nature of sup-

ply and marketing conditions is such that a given amount of cash can be assumed to purchase a reasonably identifiable quantity and quality of the intended goods, medical care is not so conveniently packaged or labeled.

What is wanted or required is often unclear, and quality is often enshrouded in mystery and superstition. A generous pension will usually buy old age security, but a generous dollar allocation for medical care may not buy adequate health services. Therein is the key to much of the complexity, the many dilemmas, and even to the prospects of success or failure of any kind of health program.

Similarly, no matter what may be the ultimate sharing between public and private auspices, we must deal very soon with the basic and growing problem of medical personnel shortages and the closely related financing of medical education—both prerequisites to successful medical care programs under either private or public auspices—just as we will have to face the delicate and complex problem of maldistribution of medical personnel and resources in either case.

In some areas it may be that the private instrumentalities have a better chance for successful dealing with some of the human and political problems. In recent years there has appeared a new type of advocate of public financing: those who simply want the government to pick up the tab and bail out the many costly and wasteful institutions now caught in a fiscal mire. They assume that if the government moved in they could continue present expensive and wasteful practices, with assured payments, whereas now the countervailing pressure of organized consumers calling for more rigorous cost accounting and quality controls appears to be growing steadily.

In other areas, it seems clear that a public program, for example coverage of the aged, has a greater chance for success. But thus far the doctrinaire opposition of leading medical societies and insurance carriers has made it impossible to discuss adequately the very real problems which would be involved in a major public program of this sort. The Forand Bill, which proposes to add limited hospitalization and perhaps surgical and nursing home benefits for the aged to the Old-Age, Survivors, and Disability program,

is currently deadlocked over such sterile either/or assumptions. The situation appears particularly ironic with respect to the insurance carriers. They appear to believe that such legislation is designed to cut off a portion of their business. Yet there is ample evidence that it could take the carriers "off the hook" with respect to the aged, allow them to furnish a better product for their logical clientele, and take much of the sting out of present attacks on the inadequacies of private health insurance. Indeed, it would probably open the path for further expansion of private health insurance by making sale of supplementary programs more attractive, just as in the case of life insurance and private pensions after establishment of the basic social security programs.

In the very nature of the American social structure and the unwritten rules of American politics, a pluralistic solution to such large problems is traditional and inevitable.

As we move forward, it is clear that more money will be needed and more, both public and private, will undoubtedly be spent. This has been the trend for many years. But money alone cannot achieve the goal. It is possible to spend more and more without commensurate achievement.

Money is indeed a great lubricator. But we must first understand more clearly what it is we want to buy and the real deterrents to its purchase. Fortunately, the growth of health insurance has created a new professional group of medical care experts—representatives of consumers' groups and of carriers—who are becoming increasingly sophisticated. It is to be hoped that, in time, their acquired skills and influence will make them effective in bargaining with the medical profession for reform. Fortunately, too, a new type of medical leadership may be emerging—doctors who understand socioeconomic problems as well as medical ones.

In any case, it is essential that we not be bemused by simple notions that single solutions can be found. We can realistically seek for progress in change, accepting the realism of John Galsworthy's dictum: Nothing is so sure to change as the status quo; nothing so unlikely to arrive as the millennium.

Medical Care—an Historical Perspective

by ODIN W. ANDERSON

SYSTEMATIC RESEARCH IN THE SOCIOECONOMICS of medical care actually began over thirty years ago when on several occasions in 1925 and 1926 a few physicians, public health practitioners, and economists met to discuss and draw up plans to study the structure of medical services in the United States. On April 1, 1926, an informal conference was held in Washington, D.C., attended by fourteen persons from these fields. Six persons were appointed to formulate a tentative series of studies and to develop plans for the establishment of a committee to conduct them. It may be of interest to list the people charged with this important and, in retrospect, historic task, if only to give some idea of their affiliations and high caliber. They were: Winford H. Smith, M.D., Director, Johns Hopkins University Hospital, chairman; Harry H. Moore, economist, University of Chicago, secretary; Michael M. Davis, medical economist, former Director of the Boston Dispensary; Walton H. Hamilton, Professor of Law, Yale University; C. -E. A. Winslow, Dr.P.H., Professor of Public Health, Yale University; and Lewellys F. Barker, M.D., private practitioner, Baltimore.

In subsequent years the names of these physician-scholars thread through events in the health field in both research and action. They met several times, formulated a suggested list of studies, and consulted with many physicians, public health practitioners, and economists regarding the proposed plans. As a result, a conference was held in Washington, D.C., on May 17, 1927, attended by about sixty persons representing the various fields interested in the proposals. They, in turn, created the Committee on the Costs of Med-

ical Care (C.C.M.C.), which was financed by six well-known foundations.

The program of study planned by the C.C.M.C. consisted of the three following groups:

1. Preliminary surveys of data showing the incidence of disease and disability requiring medical services and generally existing facilities for dealing with them
2. Studies on the cost to the family of medical services and the return accruing to the physicians and other agents furnishing such services
3. Analysis of specially organized facilities for medical care now serving particular groups of the population [1]

Later, in more succinct form, the objectives read: "Organized to study the economic aspects of the prevention and care of sickness, including the adequacy, availability and compensation of the persons and agencies concerned."

This program was proposed at a time when there were no national statistics on the extent of illness in terms of such factors as age, sex, and income. There were no national—nor even local—statistics on the use of services and, obviously, no systematized data on family expenditures for services; nor were there any organized data on the incomes of physicians and others in the health field. Health insurance as we know it today was practically nonexistent; there were examples of group practice, organized medical care in some industries, and similar systems, but these had not been studied and analyzed.

In other words, the C.C.M.C. had to conceptualize the whole field from scratch and to formulate the problem areas that needed research; it had to assemble staff, and determine what research methods and techniques were available or could be developed—a truly heroic but exciting task. All research in the social and economic aspects of medical care that has taken place since that time can find its genesis in the program formulated by the C.C.M.C. Prior to organization of the C.C.M.C.—before 1920—there had been local studies on morbidity by age, sex, family income, and

[1] Committee on the Cost of Medical Care, *The Five-Year Program of the Committee on the Cost of Medical Care, Adopted February 13, 1928*, Publication No. 1 (Washington, D.C.: the Committee, 1928), p. 14.

other measurable criteria by the Metropolitan Life Insurance Co. under the direction of Dr. Louis Dublin. After 1920 the U.S. Public Health Service launched a series of studies of the incidence of illness in a representative sample of a general population in Hagerstown, Maryland, and from these several reports were published.[2] But essentially nothing had been done to study the socioeconomics of medical care on a nationwide scale.

Nevertheless, the problem of paying for adequate medical care had presented itself. In fact, there had been a flurry of proposed legislation related to government health insurance in sixteen states during 1916 and 1917. This largely subsided within four or five years, leaving in its wake only fragmentary and unsystematized information on the nature, scope, and components of the problem from the standpoint of the public. Obviously, the suggested method of paying for health services—government health insurance—did not have enough support to survive into enacted legislation.

The period when the C.C.M.C. studies were being conducted, 1928–32, seemed to be one of watchful waiting to see what the results would be for public policy on medical care. The American Medical Association editorialized:

> Most physicians and most economists and most social workers are willing to wait until the Committee on the Cost of Medical Care, a group with which the medical profession is cooperating wholeheartedly, has brought into the situation data on which to base reasonable action for the future.[3]

Twenty-eight reports were published; twenty-seven were field studies or systematic compilations of existing data, while the last report published in 1932 contained the C.C.M.C. recommendations for action, based on the studies.

It is not necessary to present in detail the findings of the C.C.M.C., but it is pertinent to say that they spelled out as never

[2] Among these were: Edgar Sydenstricker, "The Incidence of Illness in a General Population Group," *Public Health Reports*, XL (February 13, 1925), 279–91; Selwyn D. Collins, *Economic Status and Health*, U.S. Public Health Bulletin No. 165 (Washington, D.C.: Government Printing Office, 1927).

[3] Editorial, *Journal of the American Medical Association*, XCIII (August 10, 1929), 459.

before the main components of the problem of meeting the cost of medical care and greatly assisted in the formulation of public policy. The data showed the extent to which illness falls unevenly in regard to income, age, and sex, and that costs and utilization of services likewise fall unevenly. Undoubtedly, these findings were not unexpected, but the C.C.M.C. made the problems explicit, one of the prime purposes of research bearing on public policy. In addition, the C.C.M.C. made studies of existing methods of organizing and paying for medical services as represented by plans in some industries.

The full Committee pondered the results of the twenty-seven studies produced by the technical staff and began to prepare recommendations for action. For the first time in this country over-all policy regarding medical care was to flow from a series of comprehensive organized studies. As so often happens in research findings that bear on public policy, the Committee could not always agree as a whole, and majority and minority reports were issued.

The majority of the members of the Committee were of the opinion that medical services could be organized to provide adequate service for the entire population by the application of group practice units and the insurance principle. Financing could come from either or both private and governmental sources. The minority group, while agreeing with the majority on many matters, objected both to the proposal for group practice in association with prepayment, as involving contract medicine and as inimical to good medical service, and to any form of insurance covering physicians' services unless sponsored and controlled by medical societies.

It is apparent that there was agreement on the definition of the problem for the American public but disagreement on the means of solution. This has characterized debates on medical care ever since; that is, there has been general agreement that something needs to be done, accompanied by disagreement over source of finances and method of organization. In recent years debates have moved into much more complicated considerations of the role of insurance, as we shall see presently. This, in turn, means that choice of problems for research needs constant reformulation if fact-finding is to keep pace with the issues.

When the recommendations of the C.C.M.C. were published and discussed in 1932 the country was in the depths of a depression which set the stage for the Social Security Act of 1935. This Act attempted to strengthen the existing public health programs, and made no reference to health insurance. In the original security bill there was one sentence to the effect that the Social Security Board (later called the Social Security Administration) should study the problem of health insurance and then make a report to Congress. Edwin F. Witte, secretary to the Committee on Economic Security, said: "That little line was responsible for so many telegrams to the members of Congress that the entire social security program seemed endangered until the Ways and Means Committee unanimously struck it out of the bill." [4]

Official interest in the problem of medical care and health insurance continued, however, and found expression through studies by the Bureau of Research and Statistics established by the Social Security Board. Further, Congress appropriated a considerable sum of money to the U.S. Public Health Service to conduct a large-scale study of illness in the general population, drawing on a sample of a million or so. This was conducted in 1935–36 and was known as the National Health Survey. Until the decade beginning in 1950 the studies of the C.C.M.C. and the National Health Survey were the sole sources of data on the distribution of the costs of medical care and the extent of illness. They brought systematic information for the first time on the following:

1. Extent of illness and disability in the general population
2. The extent to which illness and disability receive medical attention
3. Family expenditures for services by type of service and the distribution by magnitude of services
4. Data on utilization of various types of services
5. Examination of existing methods and plans to organize services and help families pay for them

In addition—and this was truly a pioneer venture—there was an attempt to set up standards of care in regard to types and volume of service that a given population should receive in relation to the

[4] Interdepartmental Committee to Coordinate Health and Welfare Activities, *The Nation's Health* (Washington, D.C.: Government Printing Office, 1939), p. 103.

extent and types of illness and disability.[5] Thus, for the first time, a scientific measure had been made of the extent to which the general population was approximating or falling short of a suggested standard of volume of medical care.

With this wealth of objective data emerging in the economic climate of the 1930s, it seemed that the only reason why some people were not getting adequate care was lack of money. Data on the use of services and the extent of illness in relation to family income bore out this assumption in profusion. Also, it appears that the suggested standard of volume of service was uncritically applied beyond the intentions of the authors, neither of whom wished for a literal interpretation of their standard of adequacy.

Viewed in retrospect, social and economic research in the thirties had a refreshing naïveté, and interpretations of the findings revealed supreme confidence in their meaning. It was a period of research in the health field pioneered and understandably dominated by the economist, the expert in vital statistics, and the biologist. The sociologist, the social psychologist, and the anthropologist, who added another dimension to research and to theory, came later. But in those early days the concept of unmet medical need did not appear elusive; reasons why many individuals and families did not get adequate care seemed obvious, and standards of proper volume of service were ventured and even accepted. Take, as an example, the Preface to a survey of urban families and their medical expenditures conducted during the depression, which included the following generalization:

> Estimates of the cost of adequate care for an average group of families when paid for on an individual basis according to minimum fees place the average expenditure needed at $75.50 per person per year. In contrast, the data obtained by the Bureau of Labor Statistics in the Consumer Purchases Study shows that the per person expenditures of large-city families in the median income group average from $13 to $25.[6]

[5] Roger I. Lee and Lewis W. Jones, *The Fundamentals of Good Medical Care: an Outline of the Fundamentals of Good Medical Care and an Estimate of the Service Required to Supply the Medical Needs of the United States* (Chicago: University of Chicago Press, 1933).

[6] *Family Expenditures in Selected Cities, 1935–36*, U.S. Bureau of Labor Statistics Bulletin No. 648; Study of Consumer Purchases: Urban Technical Series, Vol. V. Medical Care (Washington, D.C.: Government Printing Office, 1940), p. vii.

As a researcher in medical care too young to participate in the C.C.M.C. studies or the National Health Survey, I nevertheless experienced a vicarious thrill at the uncovering of completely new data. And, in fact, those two studies provided a base for subsequent research in which I have had the privilege to be a part. Even so, I marvel at the differences between the thirties and the fifties, differences in medical care problems and social climate calling for a reformulation of research relevant to an advanced era—research requiring new tools, new concepts, and new interpretations.

Great interest in the problem of health insurance persisted, and proposals continued for governmental and private methods. The thirties saw the establishment of the currently extensive Blue Cross Hospital plans and Blue Shield medical plans. By 1937 an interdepartmental Technical Committee on Medical Care in the Federal Government had been set up to plan and organize the National Health Assembly for 1938, using as a base the research findings accumulated to date. From 1939 to the end of the Truman Administration there were bills in Congress proposing Federal-state health insurance programs. Concurrently, the postwar period saw the beginning and rapid growth of voluntary health insurance promoted by private insurance companies. The issue during this period appeared simple: should health insurance be government sponsored or privately sponsored? Obviously, the very principle of insurance as a method had been settled.

During the 1940s there was little systematic research. The period was characterized by polemics over political issues and the burgeoning of voluntary health insurance, particularly after the war. This climate was really not conducive to research because research is not useful during heated debate; there is too much cross fire, and the contending sides select their experts as in a court trial. Moreover, at that time research was hardly necessary to show voluntary health insurance agencies that more people should be covered and that costs of medical care are financial risks for families.

The field was wide open, and the decade of the forties was one of simple quantitative expansion following the acceptance of the insurance principle. Government health insurance legislation remained stalemated in Congress, and voluntary health insurance,

confounding both the proponents and critics, showed promise by the beginning of 1950 of becoming the prevailing vehicle for financing personal health services in this country. President Truman to this day considers that the inability of his Administration to achieve government health insurance through legislation left an unfinished task. Still, he set up the President's Commission on the Health Needs of the Nation which did everything possible to assure the country that alternative ways of financing medical care would be considered. Its final report showed that voluntary health insurance had then become a force throughout the nation.[7]

When the Eisenhower Administration took office, government health insurance for the general population died as a political issue, and voluntary health insurance was, in effect, granted the breathing spell it had been asking for to work out its destiny and to demonstrate its potentialities. The proper climate for research in the social and economic aspects of personal health services was then at hand, paralleling in a very different context the period of the thirties when the C.C.M.C. was established. During the twenties there was a need for data to spell out the components of the costs of medical care facing families. These were supplied. Beginning in the fifties, there was need again to spell out the components of costs of medical care, but with a new element added—voluntary health insurance.

By 1952 voluntary health insurance was paying one half of the nation's general hospital bill and 40 percent of the surgical bill. After its rapid growth during the forties, voluntary health insurance was now ready for an evaluation of its accomplishments and clarification of problems that still needed to be solved from the standpoint of the public. Almost intuitive in their response to this need, the drug, pharmaceutical, chemical, and allied industries established Health Information Foundation in 1949 to conduct research in the social and economic aspects of the health field. By 1952 the Foundation staff had recommended studies of family costs and voluntary health insurance, using the tools of social survey methodology. The Foundation program has evolved from this

[7] President's Commission on the Health Needs of the Nation, *Building America's Health. Findings and Recommendations* (Washington, D.C.: Government Printing Office, 1951), Vol. I.

base. The patterns of research sponsorship are interesting. In the twenties American industry financed the C.C.M.C. research in the social and economic aspects of personal health services through six foundations; in 1935–36, the Federal Government financed and conducted a nationwide survey of morbidity. In the fifties, American industry organized a foundation and financed the first nationwide survey of family expenditures for medical care and voluntary health insurance; and now the Federal Government is again financing and conducting a national survey of morbidity. Another bench mark paralleling the period of the thirties has been attained.

What social and economic research in medical care is needed now? In answering this question we must assume certain priorities among current problems and issues. Since the findings of the C.C.M.C. and the National Health Survey, several massive changes, some of which I have already mentioned, have taken place and affect the choice of research: (1) a shift in source of payment; (2) a change in the age composition of the population; (3) a shift in prevailing causes of morbidity and mortality; (4) a rise in the economic well-being of the population generally; (5) changes in the pattern of medical practice; and (6) an increase in the use of health services generally.

In the fifties there have been studies exemplified by the National Morbidity Survey, the surveys of morbidity and use of services in California relating particularly to chronic illness, the various studies sponsored by Health Information Foundation, and the field studies of the Commission on Chronic Illness in Baltimore and in Hunterdon County, New Jersey. Also, the Commission on Financing of Hospital Care collected new data and assembled existing documents to bring some order to the study of financing hospital care. The present Joint Commission on Mental Illness and Health is, in like manner, bringing order to knowledge related to the problem of mental illness. And during this period there have been attempts to conceptualize the problem of unmet need and to measure it, and to conceptualize and measure quality of medical care.

Before describing needed research, then, we must ask ourselves how much we now know that is useful in planning and policy formulation. I believe the following can be listed:

1. Range and distribution of facilities and personnel
2. Range and distribution of costs by type of service for the family
3. Range and distribution of health insurance and its relative effectiveness in helping families pay for care
4. Range and distribution of utilization of various types of services
5. Crude estimates of the relationship between need and demand and of the problem of unmet need
6. A general idea of the incidence and prevalence of causes of morbidity and the causes of death.

Accomplishments in the field of health insurance, in medical care, and in related research have been impressive. Certainly one accomplishment that has been documented through research is outstanding: the fact that the utilization of hospital care and surgery varies little if at all by level of family income. This was not true as recently as twenty-five years ago. Differentials still remain, however, in use of out-of-hospital physicians' services and dental care, but economic reasons for these differentials are far less important than they once were.

At the risk of oversimplification and unintentionally ignoring specific areas, I suggest that there are three main problems with which we must now grapple. They call for the same spirit of pioneering characteristic when the C.C.M.C. began its studies, and they have the added dimension of further refining conceptualizations of medical care based on studies that have been made up to the present time. By this I mean that they require relatively new concepts of the provision and financing of care, new research tools, and new interpretations of the progress of the past twenty-five years. The three problem areas are:

1. An examination of the concept of comprehensive medical care to determine its components, how they can be provided, and how wide a range of services insurance should and can cover.

2. An examination of the costs and utilization levels of services, particularly in the hospital, because of the great concern over rising costs resulting from increasing unit cost and increasing utilization.

3. Long-range research into the problem of measuring and assuring good quality care. What are the components that can be measured, and in what context is the best quality of care provided, assuring maximum satisfaction to the provider of service, the patient, and the insuring agency?

So far it appears that cost has been the most widely used measuring stick, but cost alone is a spurious criterion for determining what is entailed in providing care for the people of this country. Thus, if we can go beyond the quantitative approach in assessing the present status of our health services and concentrate more profoundly on the aspects of quality as illustrated by these three problem areas, this country can make a great contribution to the continuing dynamism of medical care.

It seems clear to me that there is no minimum and tangible standard of achievement agreed to by policy-makers in medicine, government, insurance, business, labor, or any other segment of the American public, even after twenty-five years of rather intense health-insurance activity and development. This is due, in part, to the unique regard in which personal health services are held. And it is, without question, a powerful driving force. To aspire to less than 100 percent of a nebulous goal of perfection is to do violence to the necessarily utopian objectives of adequate services, maximum quality, and equal accessibility. Happily, the day may never come when these objectives stand still long enough to be measured by scientific yardsticks.

Issues in Medical Care

by JAMES BRINDLE

THE MEDICAL CARE SYSTEM in America today is in the midst of a sweeping revolution in its technology, organization, and financing. It is perhaps one of the most controversial public issues in America. It is characterized by some as "the best in the world," one which has made the United States the healthiest nation on earth. Some would have us believe this is all due to the private, solo practice, fee-for-service system of providing medical services. This is sheer nonsense. My thesis is that the nation's health is not the best in the world; that our system of medical care is badly organized, is characterized by a shocking absence of planning, and is seriously uncoordinated; that our system of paying for medical care—especially voluntary health insurance—is now so badly focused that the gap between the kind of medical care that we have the scientific know-how to provide and the kind of medical care Americans today are getting, is so great as to constitute a national catastrophe.

By almost any measurement, the United States does not have the best health. While it is near the top, a substantial number of countries with far less economic capacity have outstripped us. Life expectancy at birth, one of the most frequently used statistical measures of health status, is higher in eleven major nations. Twelve have a higher life expectancy at age sixty. Canada, Great Britain, New Zealand, and the Scandinavian countries consistently outrank us in most statistical measurements of health status. Complacency is unthinkable if we view our health status in the light of our tremendous economic wealth, our unlimited potential. It is not proper to compare our health record with that of countries which do not have our economic abundance; rather we must consider

America's goals in this and in other social welfare fields in relation to our potential. By this standard we are, indeed, far behind.

The supply of health personnel is another crucial index of our medical care system, and the relative position of the United States is not nearly so high as one might hope. The lack of planning to improve this situation is disheartening. The 1958 Report of the Department of Health, Education, and Welfare indicates that "under the assumption of graduation rates currently predicted for existing and planned schools, the number of physicians in 1975 will be 127 per 100,000 population, in contrast to the 1955 rate of 132 per 100,000."

Not only is our present level of planning and activity geared to no improvement in physician-population ratio, but we are rapidly losing ground. The Report goes on: "If the number of graduates were to be increased sufficiently to regain and maintain the 1955 ratio of physicians to population, the equivalent of 20 new medical schools would have to be added to the 87 scheduled for existence in 1965." Unfortunately, this story can be repeated again and again in relation to the many other health professions. And it has been too well-documented by such groups as President Truman's Commission on the Health Needs of the Nation to require repetition here.

Our voluntary health insurance system is running into serious trouble. With the rapid advances in medical science, modern medicine has become more effective and, at the same time, inherently more expensive. In the face of this development health insurance has become nothing less than essential for the wage earner as a means of budgeting a share of income for the cost of health care. Almost 125 million Americans are covered by voluntary health insurance today. While this is an impressive figure, when put into perspective it reveals a record of accomplishment which is not so remarkable. Voluntary health insurance does not provide comprehensive prepayment of medical care costs. As a matter of fact, the best of our generally available health insurance plans covers only about one third of the cost of medical care.

Over all, according to U.S. Department of Commerce figures, $15 billion was paid out in private expenditures for health care in

1957, of which only about $3 billion was "insured." The figure on health insurance enrollment hardly seems compatible with the net result that only 20 percent of our private expenditures for medical care were covered by insurance. Dr. Basil MacLean, president of the Blue Cross Association, in commenting on the dangers of misinterpreting the number of people covered, told the National Health Forum early in 1959:

> It is remarkably easy to allow oneself to become hypnotized into inactivity by these figures. Indeed, chanted long enough and loud enough, they become a siren song which has lulled into cozy sleep too many of us. A tremendous job has been done, but too much self-congratulation reflects inadequate estimates of how much needed, and still needs, to be done.

Our experience has established beyond any doubt that the system of indemnity payments for physicians' services is not a satisfactory method of paying for such services. Indemnity allowances have all too frequently constituted merely a base to which substantial out-of-pocket charges are added. This fact is so widely recognized that I shall not stop to review the evidence. In this connection, however, it is important to note that, though it has been generally assumed that attempts by Blue Shield to provide service benefits within income limitation present a satisfactory answer to this problem, our experience shows that this is not the case. In many areas, Blue Shield provides only indemnity insurance and has no income-ceiling service scheme. In other areas, ceilings are ridiculously low. In still others, income ceiling provisions are not effectively enforced.

Subscribers are more successful in securing full payment of the hospital bill. Most who are covered by Blue Cross, as well as those who have some commercial insurance policies have the benefit of a service program. Commercial carriers providing full service, of course, pay whatever is charged. Under most Blue Cross plans, hospitals are reimbursed for full costs. However, neither of these schemes furnishes incentives toward hospital economy and efficiency.

The emphasis on hospitalization and surgery in prevailing plans and the absence of substantial outpatient benefits has raised a host

of problems, an important one of which is unnecessary hospitalization. A study made by Michigan Blue Cross, in cooperation with the Michigan State Medical Society, in 1954, indicates that as much as 19 percent of hospital bed care in fifteen representative Michigan hospitals could not be considered medically justified.

Factors such as these pyramid prepayment costs. While indemnity programs sometimes keep premiums low by continually reducing benefits, Blue Cross has regularly and steadily increased premiums. Rapidly rising premiums are caused not only by justifiable improvements in hospital wage levels and working conditions and by better technical facilities, as is often contended, but also by inadequate concern for the operating efficiency of hospitals, unwillingness to enforce legitimate controls, and a reluctance to experiment with new ideas.

Faced with the problems of rising costs and consumer dissatisfaction, neither the commercial insurance companies nor Blue Cross and Blue Shield are dealing realistically with the tough fundamental problems involved. Instead, they are standing pat or, in some instances, even retreating from the principles on which they were founded.

Commercial insurance companies offer coinsurance and deductible programs and so-called "major medical" coverages in an attempt to maintain or broaden benefits and, at the same time, to meet the problem of rising premiums. Some Blue Cross and Blue Shield plans, too, are looking upon these devices as an easy way out. Such measures are a retreat from the whole concept of prepayment; they shift more of the burden of illness from the group to the sick individual. To the extent that they are effective, they constitute a barrier to needed medical care. These economic control techniques operate with no medical discrimination. The devices of coinsurance and deductible coverages can provide only temporary relief from continually increasing prepayment costs. They do absolutely nothing to solve the basic defects of our voluntary programs.

If anything, health insurance has relied too much on commercial insurance devices. Walter Reuther, president of the United Auto Workers (UAW), brought out this point in an address to the Michigan State Medical Society in 1957:

To the extent that medical societies entered prepayment to avert legislation, they were relatively less concerned with finding the best possible way for prepaying medical care. Rather than to hammer out a whole new set of insurance principles that could be properly applied to medical care, they adapted the ready-made doctrines of casualty insurance. Inappropriate as they are, they have been sanctified as "first principles" which now conceal the lack of medical orientation of too many of our health insurance programs.

I really don't believe that the average doctor, with his deep interest in medical services, is ready to adopt the insurance industry's concepts of losses rather than benefits, indemnity rather than service, financial devices to inhibit use, to eliminate the small claim and to exclude predictable expenses rather than preventive care, early diagnosis and easy access to health services.

In Michigan, Blue Shield, in 1958, introduced a program (M-75) that was developed by a committee of the State Medical Society and approved by its House of Delegates. It involved extending the service principle to the $7,500 income level, substantially enlarging the area of coverage (especially for outpatient services), and setting different fees and premiums related to various income ceilings. Even with official approval, the plan ran into substantial opposition, and in Wayne County (which includes Detroit), the Medical Society has elected a whole slate of delegates to the State Convention who are opposed to the present program. One of the leaders of the opposition, Dr. J. F. Wenzel, a vigorous opponent of M-75, raised this age-old war cry in a letter to the editor of the Detroit *Times:*

An increasing number of physicians feel that the expanded prepayment plan of Blue Shield is a step closer to state medicine because of the ease with which the state could take it over should our recession become recognized as a depression.

These physicians do not mind fighting against socialized medicine, but they do not desire to establish the instrument which will aid the arrival of state medicine. To retain his freedom, the doctor will choose wisely to see that too great a proportion of his income does not come from Blue Shield.

Such is the reaction of medical standpatters to the extension of voluntary health insurance. But such opposition will not prevail; we will have more and better health insurance.

Labor unions are not alone in seeking an expansion of prepayment and the better organization of medical care. Benson Ford, vice-president of Ford Motor Company, had this to say to a Blue Cross meeting in Milwaukee concerning the legitimate objectives of voluntary health insurance:

> . . . inclusive health care should provide to every American citizen, at a cost that he can reasonably meet, all of the services necessary to keep him healthy and productive. Ultimately it must involve preventive, diagnostic care as well as curative.

In the same speech, Mr. Ford also commented on the extent and speed with which we must develop our health insurance systems:

> . . . there must be no hard and fast barriers to the expansion of economic credit for *all* our medical needs. . . . While progress toward the ideal of an inclusive health system must be evolutionary, it must evolute visibly—at something more than a snail's pace.

Basic to some of our difficulties are problems in the field of hospital operation and programing. These problems are closely tied to the operation of our hospital insurance system. Several university groups, with foundation help, are looking at these questions. Studies at Columbia University and at the University of Michigan will furnish comprehensive analyses of hospital and medical insurance.

There is really a whole series of highly charged issues in hospital administration. One of them concerns the method of compensating pathologists, radiologists, and anesthesiologists. There is a nationwide drive by members of these specialty groups toward getting themselves on a percentage or fee basis rather than working on a salary. Actually, if everyone would be frank about it, this is really a fight for money—and not for just a little bit. A pathologist or radiologist in a major hospital, with an effective monopoly, can clear $100,000 a year. As Leonard Woodcock, vice-president of the UAW, recently told hospital administrators in Chicago:

> It's not the principle of the thing—it's the money . . . . physicians are entitled to very good financial rewards. They carry very heavy—literally, life-and-death—responsibilities. They must be liberally compensated. But when we are talking money, let's talk about just that and not delude ourselves with slogans about the free choice of radi-

ologist and the sacred pathologist-cadaver relationship that must be reinforced by a fee-for-service system of payment.

Another serious financial problem is the capital cost of hospital modernization and expansion. Many responsible for fund raising and for prepaying health care doubt that there is any practical limit to the number of hospital beds that physicians in a community will fill if they are available. Organizations like Blue Cross in Cleveland and the Metropolitan Detroit Building Fund are looking at this problem of bed availability as an important factor in controlling prepayment premiums and capital investment in health facilities. There is little doubt that the design of prepayment affects medical and hospital practice very substantially.

Medical practice itself is another item on which public attention must be focused, and here the consumer as well as the physician has an important stake. The organization of medical practice has not kept pace with the rapid technical development of medical science. There is real reason to question whether solo practice, which is the predominant pattern in the United States today, can cope with the multiplying complexities of modern medicine.

Tomorrow, hospital-centered group practice will probably prevail in medical practice. This type of medical organization was strongly recommended by the Magnuson Commission five years ago. It is a basic feature of the Health Insurance Plan of Greater New York (HIP) and the Kaiser Foundation Health Plan in California. Prominent medical educators call group practice "the medical practice form of tomorrow." Yet, it is often resisted by organized medicine.

There is also a real question about whether the quality controls of government and organized medicine adequately protect the consumer and insure a high quality of care. The primary control, of course, is licensing by state agencies. This is a one-shot business. Recently an officer of the American Medical Association (AMA) raised the question whether this licensing is an adequate device; he proposed periodic reexamination and relicensing. The specialty boards of the AMA, through examinations and certifications, give some assurance of the initial competence of specialists, but probably the most important quality control mechanism in

American medicine today is the community general hospital. Accreditation of the hospital by the Joint Commission on Accreditation (representing the American Hospital Association, the AMA, and the American College of Surgeons) requires that certain procedures aimed at controlling quality be established and maintained. These procedures include a review of surgery and of medical practice. These devices give some minimum assurance of the quality of medical care.

In its medical care program the United Mine Workers Welfare and Retirement Fund audits medical practice and hospital operations in many communities. The Mine Workers operate ten large hospitals, staffed with specialists, in the coal regions of Virginia, West Virginia, and Kentucky. In addition, in other areas, Fund physicians review and control medical care purchased through community general hospitals and physicians. Initially, the Mine Workers assumed that every physician offering service was competent in the field in which he claimed to be, and the Fund allowed beneficiaries to choose any physician they wished. Dr. Warren F. Draper, executive medical officer of the Fund, hoped initially that:

> . . . organized medicine at the national, state and county levels would see to it that these physicians rendered services of high quality within their capabilities, and utilized specialist services at Fund expense when needed in the best interest of the patient. We believed that we could rely upon physicians generally to hospitalize only those patients whose illness could be not be treated adequately in the home, physician's office or outpatient clinic.
>
> We believed that an unparalleled opportunity was afforded for organized medicine and the Fund, working together, to develop a pattern of medical care that would serve the best interests of the patient, the physician, and the one who paid the bills.

Dr. Draper's hopes were not realized. I quote from a paper he gave at the New England Hospital Assembly in March of 1958:

> As data accumulated, however, it was evident that in many places surgical diagnoses and operative surgery for Fund beneficiaries were inferior in quality, and in the amount of surgery were far in excess of that performed on others. This was confirmed by qualified surgical consultants who reviewed the records at our request or examined our

patients at medical centers to which they were transferred. Furthermore, our rates of hospital admission and length of stay were far beyond the bounds of any experience in the United States.

These facts were discussed for several years with individual physicians, state and local medical societies, at meetings especially held for the purpose, at medical advisory committee meetings, and elsewhere, but little change was brought about. It was clearly evident that county medical societies and hospital staffs are too often reluctant to supervise their colleagues and effect the drastic changes that should be made.

The row that the Mine Workers has had with the medical profession in a number of places results from the fact that the Welfare and Retirement Fund found it necessary to impose certain types of quality control. The results are interesting. They led to substantial reduction in rates of surgery and in length of hospitalization. The Fund barred the work of physicians whose work was not satisfactory and stopped using some hospitals. From his experience, Dr. Draper concludes:

1. Every physician duly licensed by the state is not competent to perform any service that any patient may require, even if he claims to be.
2. Organized medicine, while insisting that it alone possesses the authority to judge and discipline its members, has thus far been unable or unwilling to establish and enforce effective means of doing so.

Richard Carter has reached the conclusion that organized medicine itself, especially through its county and state medical societies, is not going to be able to assure high quality in medicine. He says:

. . . I must emphasize that I do not know how many physicians split fees, plunder insurance funds, or accept commissions from drugstores and diagnostic laboratories. Neither will anyone else know until some public agency uses the power of subpoena to find out. But I do know that the medical society functionary who dismisses these problems as confined to the "unethical few" has no basis for that comforting contention. The facts are that medical corruption is common knowledge wherever physicians drink coffee and swap clinical details.

What is most important about these transgressions, I am sure, is that they are not the heart of the matter. They are mere symptoms of a more profound and infinitely more offensive affliction—the jungle-type medical economics perpetuated by organized medicine.[1]

[1] Richard Carter, *The Doctor Business* (Garden City, N.Y.: Doubleday, 1958), p. 120.

It is our feeling in Labor that quality controls ought to be exercised on behalf of the consumer through prepayment programs, especially those which are community based, such as Blue Cross and Blue Shield. But the administrators of these programs and the professions and the hospitals are far from agreement on this point. Here is a place where significant and substantial failure on the part of voluntary agencies will certainly, in the not too distant future, bring governmental action.

Thus far I have outlined three serious weaknesses of our present system for medical care. First, health insurance is badly designed and subject to serious abuse. This often flows from the nature of the program rather than from deliberate intent.

The second serious problem concerns the operation of hospitals and their probable unnecessary use. To this, again, the faulty design of insurance contributes.

The third has to do with the practice of medicine. The general pattern of medical practice has not moved nearly fast enough to keep pace with technological advance. There are the beginnings of serious large-scale efforts to overcome all these difficulties. Typically, these efforts are not under official medical sponsorship. As a matter of fact, they are often opposed by medicine. These programs can be the beginning of a revolution in medical care. The best known of these plans are Group Health in Washington, D.C., the Kaiser plan, Ross-Loos, and the Group Health Cooperative of Puget Sound on the West Coast, and HIP in New York. In Detroit, with the backing of the UAW, a similar community program, the Community Health Association (CHA), is getting under way. Many other unions operate their own plans. These are group practice programs. Physicians and other health personnel are organized in integrated teams. Generally, the quality of the work can be supervised with the prepayment program itself taking on responsibility for assuring quality. Further, these programs provide a full range of medical services, including preventive care, which is not only good economics but good medicine. These plans have given a convincing demonstration that a rational organization of health services can be made to work. Substantial progress has been made in their development, and they hold high promise for the

future. In a few areas, medical societies are developing almost complete health insurance. A striking example is in Stockton, California, and the older program in King County, Washington. Across the river from Detroit, in Canada, we have Windsor Medical Service, a county medical society program, which has demonstrated that even on a fee-for-service basis complete medical insurance can be offered at a premium rate that is not out of reach of workers. While these programs do not affect the type of organization within which doctors work, they have set up control machinery which could be utilized to assure efficiency and quality. These too are pioneering efforts. Their general adoption in competition with the group practice plans like Kaiser, HIP, and even CHA in Detroit, could go very far toward sparking the extension of the existing community plans for health insurance.

It is appropriate to ask why organized medicine has not taken leadership in developing health insurance. On this point, Herman and Anne Somers have this to say:

> The doctors now feel they have eliminated the threat of governmental health insurance. They have prospered under present arrangements and they are highly confident. Many state and local societies are taking an uncompromising position . . . . are sloughing off the responsibilities they assumed earlier. Many appear determined to abandon the service principle in favor of indemnity. Fee schedules, the one device which might give indemnity insurance a chance to work, are increasingly opposed. Presumably, they see immediate financial advantage, while overlooking long-term hazards. The societies also seem to have redoubled efforts to prevent the spread of lay-sponsored, prepayment plans. In Kentucky, Colorado, Pennsylvania and Illinois, the state societies are locked in combat with the United Mine Workers Fund, ostensibly over the "free choice" issue.[2]

In 1937, when government employees in Washington, D.C., organized the Group Health Association (GHA), a nonprofit prepayment medical care and hospitalization plan, physicians were hired on a full-time salary basis to provide medical care for the members. Quoting from the Yale Law Journal of May, 1954:

> The local Medical Society, however, objected to this lay-sponsored group and employed its coercive powers to destroy the competitive

[2] Herman M. and Anne R. Somers, "Private Health Insurance Part II: Problems, Pressures and Prospects," *California Law Review*, XLVI (1958), 547–48.

threat to private practitioners. The District Medical Society expelled or otherwise disciplined several doctors hired by Group Health and . . . made it impossible for GHA to obtain consultation with fellow physicians.[3]

The Society also got most of the hospitals to deny the GHA physicians staff privileges and bed space in community hospitals. The Justice Department successfully prosecuted criminal charges against organized medicine, under the Sherman Act, for this activity. There are numerous other instances where only through lawsuits was medicine's boycott of voluntary prepayment plans overcome.

The early opposition of organized medicine to the development of voluntary health insurance, its adamant stand against any development of governmental programs except those for the indigent, its particularly strong opposition toward the modern experimental type programs like HIP in New York and the Kaiser plan in California, demonstrates that we cannot expect, from organized medicine, leadership in the development of new programs to meet the needs of the community. Why this is so, I will not guess, but I would like to quote from an interview by Lois Chevalier with Dr. Norton S. Brown, president of the New York County Medical Society. She asked Dr. Brown what he expects to accomplish during his term of office, and Dr. Brown said:

Well, for one thing, I hope to get a few more doctors to stop thinking in clichés. The medical profession is rapidly losing the initiative in health matters because we're not using diagnostic objectivity in economic and social problems. We're bemused by slogans and pat phrases that no longer have much to do with reality. If we don't soon begin to think straight, we may really end up as hirelings.[4]

Dr. Brown's fears are not imaginary.

The negative attitude of medicine is coming to be widely noted in popular literature. Scarcely one of the large-circulation magazines has failed to point out the lack of imagination and leadership or the obstructionist tactics of organized medicine in relation to

[3] David R. Hyde and Payson Wolff, "The American Medical Association: Power, Purpose and Politics in Organized Medicine," *Yale Law Journal,* LXIII (1954), p. 990.

[4] Article: "You're Not Running a Private Concession"—Norton S. Brown, M.D., as interviewed by Lois Chevalier for *Medical Economics,* January 5, 1959.

new developments. Even when the AMA, as it did in its report of the Commission on Medical Care Plans, praises group practice prepayment programs, we note violent reaction from the Colorado Medical Society and the American Academy of General Practice against any compromise with the outmoded doctrines of "free choice."

Two recent popular books [5] document the negative role of medicine in the development of health insurance. Congressmen are becoming less affected by the recommendations of official medicine concerning social security and health programs. I recently heard a prominent lobbyist say that when a physician cries "socialized medicine" to a congressman, he gets a laugh. When doctors run down Britain's national health program, they frequently meet with an objective evaluation of our sister nation's medical plan from someone who has been in England and seen it work.

We must reconcile ourselves to the fact that massive injections of Federal financing are needed in medical fields. Despite the present Administration's reluctance, Congressional recommendations exceed the Administration's budget in the area of clinical research. Still more Federal money is needed for research in administration and operation of health care plans, and there should be subsidies to experimental programs involving the group practice of medicine in a hospital setting.

In medical education, if we are even to keep the supply of professional personnel in line with population growth, we will need heavy Federal subsidies, not only to construct medical and dental schools and other types of educational institutions, but to finance their operations.

There is still substantial racial discrimination in American hospitals and there is the real question whether Negroes get their fair share of acceptance into the student body of America's medical schools. Discrimination in many hospitals is against staff, internships, residencies, and patients. It must be eradicated.

There is substantial waste—and worse—in our whole system for providing pharmaceuticals. Richard Carter writes: "Secret rebates

[5] Carter, *op. cit.*, and Hank Bloomgarden, *Before We Sleep* (New York: Putnam, 1958).

from druggists and suppliers; open retailing in physicians' offices; organized medicine's increased tolerance of individual commercialism—these phenomena upset anyone who thinks that the physician should be dedicated to human well-being." [6]

Our pattern of national voluntary health agencies has received much needed criticism. Leo Perlis, director of AFL-CIO Community Services Activities, is urging all the national health agencies to raise money in a united way, either through Community Chest and United Funds or a once-a-year independent drive for funds. The present chaotic and competitive system of fund raising by categories of disease or by groups served, which bears only a fortuitous relationship to need, must be reformed. Social welfare workers can have a big role in the rationalization of this system.

I have discussed the inadequacies of health insurance and the organization of medical practice. Similar unkind words could probably be said about many of the health programs operated by health and welfare agencies, both public and private. Too many of these programs have the same defects as our voluntary health insurance and medical practice. Frequently, the board and the staff of a voluntary agency seek help only from the local or state medical society in setting up a program; and hence they are oriented to the present fee-for-service, solo-practice scheme and lack quality controls. It is important that laymen responsible for the design of such governmental and voluntary programs seek their models in more adequate programs. The same kind of controls that operate in HIP and the Kaiser plan could be adapted to many voluntary health programs.

There are also several basic difficulties with our medical care programs for the indigent. The typical large hospital clinic too often does not treat patients with dignity and consideration. I talked recently to the outpatient director of a large university hospital. He said that patients usually take a lot of abuse, which comes to his attention only when someone who has been used to paying his own way falls on evil days and gets enmeshed in the clinic machinery. The reaction is often violent. Clinic programs must be humanized.

[6] Carter, *op. cit.*, p. 135.

To cover all the difficulties of America's present health system is considerably beyond the compass of this discussion, but I hope I have at least left the impression that there are important battles to be fought in securing for America a medical care system which is really the best attainable. Easy questions are easily answered. In a democracy like ours it is in the extent to which men and women of good faith can fight for and obtain progress in the controversial areas which is the measure of America's greatness.

Alcoholism Is Everybody's Problem

by JOHN R. PHILP, M.D.

ALCOHOLISM IS EVERYBODY'S PROBLEM. Probably no one is untouched by it. It is a problem of such magnitude that it is considered to be one of the most serious public health problems of our times. Alcoholism means different things to different people. The word "alcoholism" is used as a verbal umbrella to cover a variety of drinking patterns and behavior. To some, alcoholism is a moral condition, a weakness, a lack of will power. To others, alcoholism is an illness, a disease, a condition. Much confusion has existed about alcoholism, and only in the last few years has serious attention been given to the problem by the various scientific and professional disciplines.

To city and county officials, alcoholism is a condition which, whether directly or indirectly, affects the health and welfare of the community. In California alcoholism is estimated to cost local governments between $25 million and $30 million per year in policing, welfare, and medical costs. Alcoholism accounts for one fifth of all admissions to California's state mental hospitals. Alcoholism is a problem encountered daily in the intake of the state's correctional institutions. Nearly one half of the arrests in California each year are for drunkenness; in some cities the rate is as high as 80 percent.

To the public health worker the prevalence of alcoholism appears enormous. According to accepted estimates, alcoholism is found in 4.5 percent of the nation's adult population. In California alcoholism is found in an estimated 7 percent of the state's adult population. Alcoholism is a gradually increasing problem in the United States, and it has been shown to have a marked in-

fluence on mortality. To the medical profession, alcoholism is a frustrating problem because of the various physical and emotional symptoms displayed by the patient. The alcoholic often requires more patience and understanding and the application of broader skills than are needed by the nonalcoholic patient. The treatment of alcoholism is time-consuming and draws heavily upon the emotional resources of the physician.

To the businessman and employee, alcoholism is a sickness that costs time and money, saps initiative, and cuts production. Industry has labeled alcoholism its billion-dollar headache. To the public assistance and voluntary agencies, alcoholism is a blight on the community which brings physical, emotional, and economic crises to thousands of families. It is undoubtedly a contributing factor in indigency and is involved in all forms of public support.

To the practicing alcoholic and the recovered alcoholic, alcoholism is a state of physical and mental anxiety which is relieved only by constant sobriety and a radical change in reaction to life situations. Although an alcoholic is usually a practicing drunk, by no means are all drunkards alcoholics. The alcoholic drinks to live and has passed the point where control of his drinking is physically or emotionally possible. At this point, recovery is impossible without assistance.

To the public, alcoholism is an enigma, an illness or disease which attacks the fiber of society individually and collectively. To many it is a troublesome and confusing problem, uncomfortable to face or discuss. Society approves drinking but condemns the effect of uncontrolled drinking. Within the last two years the public has heard much about the seriousness and extent of alcoholism but is confused about its nature and what can be done about it.

No definition of alcoholism is acceptable to everyone. Although alcoholism in the last few years has popularly been termed an illness or disease, this concept has not been accepted by many, particularly within the health profession. Although it has been helpful to the alcoholic to learn he is suffering from an illness rather than from a moral weakness or insanity, the physician, the psychiatrist, the psychologist, the social worker, and others have been reluctant to accept the concept of alcoholism as a disease and often

prefer to view alcoholism as a symptom of a deep emotional problem or disturbance.

For the present, it is sufficient to consider alcoholism as a condition or a process that is chronic, progressive, and characterized by drinking to an extent which interferes with the emotional, social, family, or economic life of the individual. Whether this condition is an illness or a symptom is not an important consideration at the moment. Regardless of its nature, alcoholism must be attacked directly. By analogy, a patient with a high fever, regardless of cause, has a condition which must be directly attacked if he is to survive. Once the fever is under control a more precise evaluation can be made in order to determine those factors which created the fever and what might be done to eliminate or alleviate them. So it is with alcoholism. It too must be attacked directly, both on an individual and a community level. Experiences have demonstrated that many alcoholics can be helped through the application of existing treatment and rehabilitation methods. Even though these methods are not perfect, they can and need to be applied on a broadened scale through organized community programs.

Alcoholism can be viewed as a continuum in which, from left to right, the alcoholic progresses from "normal" drinking behavior to drinking behavior which may indicate a problem, then to drinking behavior with definite warning signs of alcoholism, and finally to chronic drinking with obvious evidence of the condition. Treatment efforts, as well as community planning, to date have been directed primarily at the chronic alcoholic. One of the groups which has been most successful in helping the chronic alcoholic is Alcoholics Anonymous. A.A. is a program which attracts but does not solicit new members. Thousands of alcoholics have recovered sobriety through the twelve steps and traditions of A.A., but A.A. can help only those who seek its assistance. The health profession has learned much from A.A. as A.A. has demonstrated to the professions and to the world that the alcoholic problem is far from hopeless. More and more clinics, community groups, and individual therapists are attempting to reach the early alcoholic to interrupt progression of the disease.

What, then, needs to be done about alcoholism? What are the

goals and objectives? What are the important needs at the moment? Alcoholism is everybody's problem because a successful attack on it requires the professional skills of many disciplines working in the climate of an informed and organized community. The over-all goals and objectives, therefore, are to develop within all professional disciplines concerned the appropriate skills and understanding more adequately to deal with the problem, and to make treatment of alcoholism a part of the community's organized health programs. Although specialists and technical experts will be needed, the greater need is for the upgrading of skills in all professional workers concerned. Also, although specialized programs may be useful and necessary, the final objective is the integration of these activities into organized community services. For the individual physicians, psychiatrists, social workers, psychologists, and others this will mean the learning and integration of the necessary skills as a part of professional competence. At the graduate and undergraduate level the various professional schools must more adequately teach about alcoholism. As a part of the general curricula, practical experience in dealing with alcoholics will be required. At the practitioner level it will be necessary to work with the various organized postgraduate organizations and professional associations to develop more adequate and realistic postgraduate training activities.

On the community level, alcoholism programs need a broad medical and mental health base. Such broad programs must be concerned with the spectrum of needs, including adequate personnel, training opportunities, broad-gauge research, and changes in the patterns of services now available. It will be well for programs on alcoholism to be closely connected with university centers. Its experts should come more and more from people soundly trained as physicians, neurophysiologists, psychologists, sociologists, and social workers. They should not be experts in the specialty of alcoholism who happen to have previous training in medicine, psychology, or sociology; they need to be primarily competent in their own profession. They need to be individuals who can always look at the specific in light of the general. Alcoholism programs must also both in planning and in practice be tied to all other com-

munity programs concerned with people. Who should participate in this program? All health and welfare organizations, perhaps more specifically, health, mental health, rehabilitation, welfare, and education. This will require the highest degree of community planning and organization. It will also require leadership on the part of individuals or agencies if it is to be brought about.

There are many gaps in our knowledge, but one cannot delay action until all pieces of the puzzle fit into place. The final answer to alcoholism will come through prevention. History has shown that no mass disease of man was ever controlled through treatment alone. Only through research, studies, and investigations can adequate preventive measures be developed. High on the priority list of steps to be taken are the following:

1. An understanding of the pattern of alcohol usage must be acquired. Although some studies have shown particular aspects of the problem, at the moment there is not a complete picture. It is not known who drinks, when and why, under what influences, and under what conditions. It is not known if there are substitutes or what might be called alcohol "equivalents."

2. Community studies are needed. As a part of understanding alcohol usage a number of questions must be asked which can only be answered by appropriate sociocultural studies on the community level. How does a man deal with crises in certain situations? To whom does he turn and what are the roles of the various agencies and institutions? There is a need for better incidence and prevalence studies and information.

3. There is an urgent need for the evaluation of present programs and the institution of new ones. There is interest and, at times, political pressure for the development of treatment facilities. Obviously, alcoholics must be treated by all known available means, but at the same time it must be realized that treatment is not the final answer to the problem of alcoholism. Clinical programs should be evaluated and proved, studied and changed, and new and imaginative methods initiated.

4. There is a language difficulty in the alcoholism field. This difficulty must be solved by the development of an understandable and accepted professional nomenclature useful to the various dis-

ciplines. It will be necessary to develop terminology useful and understandable in communicating with the lay public.

These are just a few of the more obvious needs in the development of a community approach to alcoholism. Alcoholism is everybody's problem because it becomes the responsibility of every professional worker, regardless of the agency or activity in which he is involved, to become more understanding and skillful in the management of this everyday problem. It also becomes the responsibility of each citizen to understand alcoholism to the extent that community programs can be adequately planned and integrated and to the extent that many times he will be a part of and actively contribute to the total plan.

Rehabilitation of the Mentally Ill Aging

by DAVID FREEMAN

IN 1957 THE CALIFORNIA STATE LEGISLATURE allocated personnel to the Department of Mental Hygiene with the intent that they be used to conduct special projects in treatment of the mentally ill in state hospitals. New ideas and methods, such as the therapeutic community, might be tried; or standard services might be provided under conditions as close to ideal as possible, such as assigning a full psychiatric team to a single ward. Would the projects show ways to improve treatment or stimulate staff to try new methods? Perhaps they would yield data to support requests for higher staffing standards. These were some potential values in the experiments.

At Metropolitan State Hospital, then a hospital of 2,500 patients, three projects were started. One was designed for intensive treatment of acutely ill, newly admitted patients; a second, to treat chronically ill patients in a therapeutic community; and the third called for an interdisciplinary team to provide full-scale services on a custodial ward of geriatric patients. This is a report on the third project, with emphasis on the contributions of social work toward rehabilitating the aging, long-term patients.

The ward selected for the project was Ward 6. The hospital was founded in 1916, and Ward 6 was one of the original buildings. The normal bed capacity is fifty-six beds. However, state hospitals are chronically overcrowded, and during the project this ward had eighty-three beds.

A survey of the population of Ward 6 at the start of the project, which was conducted from September, 1957, to July, 1958, showed

that of eighty-three patients, twenty-two were capable of living outside the hospital. An additional twenty-two patients were regarded as able to attempt living outside. Social work services were concentrated on these forty-four patients.

The tasks for social work were to motivate patients to give up institutional existence; to enable them to enter into planning to return to their own homes or to go to family care homes; and to sustain them in the community when they returned to it.

Those patients who would go to family care homes comprised a group with common needs and aims. Social group work was viewed as a specific treatment method, therefore, with which to motivate and prepare the patients to leave the hospital and to place and sustain them in a new environment. Extending the group approach, placements were to be made in a single community. Resources of the community would be organized for the patients, and they would continue to receive services as a group.

Social casework was the principal social work method used in the project. Stress and conflict in family relationships are bound up with removal of a patient from his home and his commitment to a mental hospital. If these are not reduced and clarified, the patient's return home may end in a recurrence of his illness. When his relatives do not plan to take him, but he believes they will, the idea of a substitute home will lack meaning. For the measures of group work in preparing patients for placement in family care homes to take root, therefore, parallel casework efforts were required to settle problems in the relations of patients to their families. Also to casework went the responsibilities to find and license family care homes and to organize resources in the community for the use of the patients.

The project team consisted of one full-time psychiatrist, one half-time psychologist, ten nursing personnel for all shifts, one full-time hospital social caseworker, two hospital social group work students from the School of Social Work of the University of Southern California, and three part-time field social workers, two of whom were caseworkers and the third a group worker. The team met weekly to plan and coordinate its work.

In California, field social workers are not attached to hospitals.

They are organized under a separate division, the Bureau of Social Work. Their function is to provide services in communities to patients of all state hospitals who are placed on leave of absence. For purposes of the project, part of their time was devoted exclusively to Metropolitan State Hospital. As part of the treatment team, they met regularly with hospital staff.

The original objective of the geriatrics project was to study the effects of increasing the personnel-patient ratio on patients of the older age group. Corollary studies and objectives originally conceived were:

1. To study any improvement in hospital adjustment and adaptation
2. To study any changes in mental status which various therapies might produce
3. To study changes in the discharge rate
4. To study the various psychiatric diagnoses found in this age group with respect to etiology, therapy, and management
5. To study factors limiting to patient movement found in the areas of physical health, psychiatric conditions, and social problems
6. To determine the most efficient methods to employ available personnel of various disciplines with respect to optimum coverage

Not all these objectives were reached. The contributions of social work toward some of the goals are reflected in this discussion.

The previous program on the ward was fairly representative of the standard or average program on continuous treatment wards in recent years. Between August, 1956, and September, 1957, the ward had had eight different physicians in charge. Each of these physicians had two or three other wards, with a representative case load of 180 to 220 patients. There was no regular psychologist. The social worker to whom the ward was assigned covered as his regular assignment two to four other wards in addition to Ward 6. There was little or no socialization program, no occupational therapy except for the occasional patient who was sent to the Occupational Therapy shop, few patients with ground privileges, and little movement out of the hospital on leave of absence or home visit. Patients

spent the greater part of the day sitting, either on the ward or in the ward yard.

Although the project is considered a geriatrics project, some difficulties were met in assembling a geriatrics sample. In general medicine and by lay standards, age sixty-five or seventy is considered the geriatric period. In psychiatry, however, some diagnoses generally regarded as geriatric or accompanying aging may have their onset at an earlier age. Our sample was representative of the population found on geriatric wards in most state hospitals.

By age the patient group breaks down as follows:

Of the eighty-three patients, forty-seven were over sixty-five years of age, nineteen were between fifty-five and sixty-four, ten ranged from fifty to fifty-four, and seven were under fifty.

In length of time in the hospital, the largest number, thirty-two, had been in the hospital between one and two years. Twenty-four patients had been hospitalized for two to five years. Six had been patients for five to ten years; four, for ten to twenty years; and nine, for over twenty years. Eight patients had been in the hospital for less than a year.

The largest number of patients, fifty-three, carried the diagnosis chronic brain syndrome. Schizophrenia was the diagnosis of thirteen; general paresis, of seven; manic depression, of four. Two cases were diagnosed as involutional depression; two, mental deficiency; one, presenile psychosis; and one, psychoneurosis.

In addition to social work, treatment methods used in the project included individual and group psychotherapy, electroshock therapy, tranquilizing drugs, and physical medicine. Occupational, recreational, and musical rehabilitative therapies were used. Volunteers conducted parties and various social activities on the wards, supplied food and transportation for numerous excursions into the community. Primarily, they were companions to patients.

The first step taken by the hospital caseworker assigned to the project was to survey the ward population. She interviewed each patient, explaining the program planned for the ward. For many patients this interview was the first opportunity to express feelings about being in the hospital and to relate the circumstances which led to their hospitalization. Their questions were answered, re-

quests taken, and the worker inquired into their ideas of future plans. She obtained information about their families and their resources for planning.

A survey was made of relatives to identify their relationship to the patient, where they lived, and their readiness to enter into plans for the patient. Of the forty-four patients with whom leave planing would be attempted, twenty-seven had legally responsible relatives—spouses, adult children, or parents. Four among these were interested in participating in leave planning. Eight patients had relatives not legally responsible, that is, brothers and sisters. Nine patients had no relatives. Seventy-eight percent of the patients on the ward had no place to which to go outside the hospital.

The caseworker extended services to patients aimed at improving their welfare and life in the hospital. Help was found to obtain such things as dentures, eyeglasses, prostheses, and so forth. Referrals or direct contacts were made to establish financial resources available through Social Security, veterans' pensions, and private sources. At the Christmas season, it was suggested that some relatives would be interested in social activities for patients on the ward. They were invited by the caseworker to meet with her to plan a Christmas program. The relatives who participated decided to continue as an organized group, and each month thereafter they held a party on the ward for the patients. Their activity not only benefited the patients, but gave them satisfaction and a broadened view of the work and problems of the hospital.

The types of problems met in casework with families reflected the fears and rejecting attitudes frequently met in relatives. Reasons usually advanced by relatives for not taking patients were lack of finances, inadequate housing, inability to supervise the person, poor health, disbelief in the medical opinion that patients could get along outside the hospital, and changed patterns of living in which the patient would have no place.

The following case, an extreme example of the problems presented by relatives, has typical features as well:

Mr. B., sixty years of age, had been in the hospital for a year and a half. His family, consisting of his wife and married daughter, visited irregularly. When the caseworker first made contact with them, they

expressed affection and responsibility for the patient and stated they wished to take him home. The wife was employed and doubted that she could provide the degree of supervision she felt he needed. However, the daughter would take the patient if her husband agreed. Subsequent interviews did not succeed in achieving a definite plan with the relatives, and since the patient was able to leave the hospital, placement in a family care home was proposed. The wife was shocked that a home with "strangers" was being considered and said she would rather see her husband "dead" than in any place other than home or the hospital.

Interviews with the patient and his wife over a period of months could bring no resolution of the conflicts, and family care placement became the plan for the patient. On the surface, this solution was finally accepted. After the patient was placed, the wife was dissatisfied with the home, its lack of public transportation, and the "foreign" background of the caretakers. She did definitely state, finally, that she could not take her husband, but he continued to seek and hope for return to his own home.

To prepare the patients selected as definite prospects for leave of absence outside the hospital, to motivate them to leave by use of group methods, was the assignment given to social group work interns having their field-work placements at the hospital. Each intern formed a group, serving a total of nineteen patients. From their groups came fourteen patients who were ultimately placed in family care homes. The aims of the group workers were: (1) to help patients enter into and establish relationships; (2) to assist patients to test their ideas and actions against the ideas and acts of others; (3) to help them experience support from others; (4) to develop in them confidence and self-esteem; and (5) to aid them to know of, and be ready for, changes they would meet in returning to the community. The work covered a period of seven months. Thirty-two weekly meetings were held in each group.

In preliminary steps, the interns visited the ward, becoming familiar with its routines and life. They conducted interviews, presenting the idea of participating in a group experience to individual patients. Most patients were pleased to be receiving attention, but they were skeptical as to how the group could help them or of what they would be expected to do.

In the initial phase of work with the groups, the aim of the group

workers was to enable the patients to participate in normal social experiences. The ultimate aim of placement in family care homes was not presented since plans were not yet definite. The first meetings with patients were intended to reduce fears, suspicions, and anxieties. Informal social activities produced a relaxed atmosphere. Patients used discussion periods to complain about conditions on the ward.

Encouraged by the group workers, some patients gave increased effort to performing ward duties. One group member who had always resisted doing work on the ward took pride in cleaning the meeting room. Other patients participated in preparing the room and in making and serving coffee at the meetings. Their increasing interest in relating to others was shown by the patients in writing letters to volunteers and others to thank them for their help. One group made a bulletin board for the ward.

Several patients were helped to accept their limitations. One patient with brain trauma and a crippled leg, who insisted that he could carry on his former jobs as a telephone lineman, refused to participate in group activities that involved walking. Midway in his experience with the group he began to use a cane. Able patients helped the less able ones. Ground parole was given to some patients provided they used the "buddy system," going out on the grounds in the company of more responsible patients. Following up on this progress, the group workers began to hold meetings out-of-doors.

To give the patients contact with the hospital beyond their own ward, walking tours were taken on the grounds. This activity was used also for the purpose of preparing the men for trips outside the hospital.

With the active help of volunteers, a series of field trips became a major part of the group program to assist the patients to adapt to the community. Trained by the Coordinator of Volunteers in the Rehabilitation Therapy Department, the volunteers were prepared to relate to patients and to supply various kinds of assistance. They were enlisted now to furnish transportation and to act as companions to the patients on excursions led by the group workers. Regularly, other members of the team went on the trips, particularly

the ward caseworker, the field caseworker, and the field group worker.

At some time on each trip the groups usually stopped at a coffee shop. These occasions were social experiences for the patients and permitted team members to see the patients' behavior outside the ward environment. The following excerpt from the group worker's record indicates some of the effects of these occasions on the patients:

> Mr. C. was quiet and seemed to eat compulsively. . . . He did, however, graciously offer to give Mr. A. his pie when he received it first. Mr. A. declined, insisting that Mr. C. have it. Mr. S. talked at the table more than I have seen him before. He conversed in complete sentences, which was unusual for him. I heard him remark to the volunteers on incidents in his personal life, something he never discussed. He also lit Mrs. R's cigarette, the volunteer, and was most affable. He scarcely pulled at his eyes and neck (his customary mannerisms) while at the table. Mr. B. was most sociable and conversed appropriately. He lightly flirted with the women and seemed quite pleased.[1]

From these normal social experiences the patients gained self-confidence in social life. This phase of their treatment by the social group workers lasted for three and one half months.

The next phase was preparation for placement in family care homes. Plans for placement were now definite, and the patients were informed. Their confidence faltered. Some patients reacted by holding tighter to hopes to return to their families, though casework had made it clear their families would not take them. Acute fear of leaving the institution affected others, and they absented themselves from group meetings or withdrew from participation if they attended. The interns worked on the problems of separation in two ways. First, through discussion they helped patients to recognize their feelings toward leaving the hospital, their feelings of abandonment by relatives. The patients were helped to look more closely than they had at the kind of life they would enter into outside and at the kinds of support that would be available to them, such as medical services, casework, and group work. Secondly, program activity was expanded and brought to focus

[1] Henry Lipman and Janet Paine, "Social Service Group Workers' Report," Appendix to final report on geriatric research project at Metropolitan State Hospital.

by a series of trips miles away to Whittier, the community selected for the experiment. (It was felt that Whittier, with its Quaker tradition would be receptive.) Again the services of volunteers were utilized to take the patients on trips to various facilities, such as the Whittier parks, library, shopping centers, and the community center.

While the patients were being prepared for placement, the field worker was engaged in finding family care homes and organizing community resources for the care of the patients. The worker opened her efforts by conferring with the feature editor of the Whittier *News,* the local daily newspaper. He wrote and published an article on the Ward 6 project. At the same time the worker ran a classified ad six times.

Altogether, there were sixty responses to this publicity. Ten people approached the worker after reading the appeal for homes in the story, five after reading the story and the ad, and from the ad alone she received forty-five replies. The majority of the applications were eliminated either by telephone screening, personal interviews, or observation of the applicant's circumstances. Insufficient income (the caretaker of a family care home must not depend on payments for patient care for his own support), inability to meet housing requirements, and unsuitable personality were disqualifying factors.

One resource the worker used to find persons interested in becoming caretakers was the Whittier Ministerial Association. She distributed to the ministers 500 copies of a description of the project entitled the "Ward 6 Story." The copies were posted on church bulletin boards and distributed to church groups. There were twelve responses, none of which, unfortunately, was suitable.

Twelve applicants were considered good potential family caretakers, but their homes were not suitable because of their geographic location. These were referred to the Bureau of Social Work Family Care Department for general use. Eight applicants, representing a patient capacity of nineteen, remained. These were reduced to five when one applicant withdrew because of illness and two withdrew during certification because, in one instance, relatives joined the family household and in the other disinterest on

the part of the husband ruled out the plan. Accommodations for five patients were lost by these changes. Homes with space for fourteen patients remained, and these were certified.

Prior to actual placement, a major event was held. The patients were brought together with the family caretakers at a picnic. The entire psychiatric treatment team, doctor, ward technicians, social workers, psychologist, volunteers, patients, and caretakers participated. The occasion permitted patients and caretakers to become acquainted and gave the latter an opportunity to talk with lay people like themselves, the volunteers, about work with patients. A week after the picnic, the patients went to caretakers' homes for a day's visit, further preparing for placement. Some had dinner with the families.

After the placements were made, the first meetings of the entire group who had left the hospital were held. To terminate and transfer the groups to the field social group worker with minimum stress on the patients, it was decided that the first two meetings held after placement would be led by the hospital group workers. Maintaining their relationships with the groups after placement supported the patients in the transition. The field social group worker attended these meetings, and the full responsibility for group work with the patients then passed to him. He would continue to meet with the group, serving them in the community with social and recreational programs.

To assess the resources which might be utilized for the patients and learn the attitudes of community agencies and groups toward the placement of patients, the field worker conferred with representatives of the Whittier Recreation Department, County of Los Angeles Community Services Department (operating in Whittier), Whittier College, Whittier Mental Health Association, and the Whittier Red Cross Chapter. All favored the project. The Recreation Department Superintendent offered the local recreational facilities in the parks and in the community service building for the patients to use on an individual basis as each might discover an area of interest to meet his need. The patients were invited to participate in activities of the Senior Citizens Clubs. Again, the pa-

tients would approach these clubs on an individual basis, for presentation of the patients as an identified group was discouraged. They were to meet as a group, however, with the field social group worker to maintain the relationships established in the hospital. For this purpose, transportation was needed, and the field worker got in touch with two groups specifically to obtain volunteers who would drive patients to the meetings and to other events. She was unable to obtain this assistance and felt that the reluctance to provide it was related to the apprehension of lay persons, deriving from inexperience, of coming into direct contact with people from a mental hospital. Hospital volunteers and the Whittier Red Cross Chapter filled this gap.

Another service the field worker developed was that of immediate medical aid. She obtained an agreement with the Los Angeles County Medical Aid District office whereby any of these patients would receive emergency treatment in the home or in a physician's office without delay to clear the usual county eligibility requirements. She set up a system of identification and procedure with the supervisor of the district to implement the arrangement. The plan was put to test within ten days when one patient became ill and prompt medical treatment was obtained.

After the homes were found and resources assembled, the actual job of licensing the homes was carried out by a second field caseworker, a specialist in the family care program who would be assigned to follow up the patients after placement. In retrospect, he felt that he should have joined the project at an earlier time in order to have become better acquainted with the patients and with other members of the team. He found that using a group method in making the transition from hospital to family care homes, such as the picnic to introduce patients and caretakers to each other and the visits to the homes for dinner, were excellent measures and enabled the patients to make comfortable initial adjustments in the homes.

Some of the values of the project are indicated in statistics which compare patient movement prior to the project and during the period of the project:

	CONTROL PERIOD (*Sept. 1, 1956–June 30, 1957*)	PROJECT PERIOD (*Sept. 1, 1957–June 30, 1958*)
Ground parole	6	42
Home visits	27	150
Leave of absence	5	19
Discharged	6	15
Deported	1	1
Family care		16
Work placement		1
Total dismissed from hospital	11	52

In this project standard therapies were applied intensively by a psychiatric team to treat mentally ill geriatrics patients in a state hospital. Under ordinary conditions of care, many of the same therapies would be applied extensively by cooperating but uncoordinated personnel. Sufficient, well-organized personnel, the project shows, produce better care for patients than insufficient, loosely organized personnel.

For the job of returning patients to the community and sustaining them there, social work is the key discipline. Social work supplies the skills and methods to bring the patient and his family together, or to bring the patient and a substitute family together if his true family has disintegrated; to stir patients out of the torpor of institutional life and stimulate their interest in social satisfactions; and to assemble the resources of a community for their use and welfare.

When these skills and methods are joined with those of other disciplines in a state hospital, patients can emerge from the institution and enter community life. When personnel is not sufficient, patients languish in hospitals. The experience of this project suggests again prevailing convictions in the mental health field that the treatment of mental illness may be centered in the community, and that if hospitals are staffed adequately, new beds are not needed.

Social Welfare in the Soviet Union

by CHARLES I. SCHOTTLAND

SOCIAL WORK IN THE UNITED STATES is not performed in a vacuum. Major social, economic, and political developments affect the direction, the philosophy, the financing, and the place of social work in the constellation of programs and activities making up American life.

And in the year 1959 it is axiomatic that programs and developments in the United States will be affected by the Union of Soviet Socialist Republics. Every school child knows that we are engaged in a cold war, with the two world giants, the United States and the Soviet Union, constantly exploring and probing each other's physical and ideological strength—probes and explorations which undoubtedly will affect social work programs. For example, when the Soviet Union put a satellite into the atmosphere, the achievement had a profound influence on American life, on our American educational system, and on our expenditures for schools and for scientific and military research. All of these affect the climate in which social work practices and in which social work competes for funds with other programs. Social work in the United States will be practiced in this climate for many years to come. As President Eisenhower said, "We must be prepared during the years ahead to live in a world in which tension and bickering between free nations and the Soviets will be daily experiences."

It is, therefore, of significance and interest to the social work community that our Department of State has taken leadership in encouraging cultural exchanges between the Soviet Union and the United States. Experts in the fields of health, education, agriculture, business, and science have gone to the Soviet Union, and similar teams have come from the Soviet Union to the United States.

One of these exchanges was in the field of social security and social welfare. Five persons constituted the American team which spent thirty days in intensified study of the Soviet Union's social security and welfare programs in 1958. We did not return as experts on the Soviet Union but we did, I believe, learn more about the Soviet Union's social security system than had been known officially in this country and certainly more than has appeared in any publication. Our team consisted of Victor Christgau, Director of the Bureau of Old-Age and Survivors Insurance, Social Security Administration; Arthur Hess, Assistant Director in charge of Division of Disability Operations, Bureau of Old-Age and Survivors Insurance; Mrs. Corinne Wolfe, Director of Training, Bureau of Public Assistance; Robert J. Myers, Chief Actuary, Social Security Administration; and myself as Commissioner of Social Security, heading the team. As an official delegation, we were guests of the Soviet government, were received with overwhelming hospitality, and given access to individuals, officials, and records not usually available to American visitors.

We made a serious effort to understand Soviet life and, specifically, the place of social security in it. Because our primary task was to study social security, we were unable in the limited time available to make an equally extensive study of the social services not related to social security. We interviewed many officials, from cabinet ministers to clerks; we spoke to dozens of citizens, from superintendents of large factories to teenagers bathing in the Black Sea; we visited over sixty installations in four republics—old peoples' homes, hospitals, day care centers, houses of culture, factories, farms, and a variety of other institutions. We brought back voluminous literature, some of which has already been translated. Here I shall merely summarize what will appear in our more extensive report, which will be published before long.

Much has been written about the Soviet Union, and in the year 1959 books on the Soviet Union in the English language will run into the dozens. And as in previous years, the impressions will be different, the opinions contradictory; even ordinary facts will be presented from different points of view.

It is perhaps inevitable that this should be so because the Soviet

Union is a land of great extremes and strange contradictions. Covering one sixth of the earth's land surface, with a population of over two hundred million, with eighty-nine different nationalities among its people, and with many different languages, the Soviet Union inevitably impresses the visitor with its great contrasts. Thus, the sophisticated European Russian-speaking Muscovite appears to have little in common with the Uzbek-speaking Moslem shepherd of Uzbekistan. Everywhere we went we met most friendly and cordial people and were treated with the greatest hospitality; but the posters and billboards brand the United States as a warmonger and murderer. Soviet citizens decry American civilization, but they eagerly read Theodore Dreiser, Mark Twain, Jack London, and James Fenimore Cooper. Everywhere there was fervent talk of peace; yet nowhere in the Western world would one see so many military uniforms. There is a shortage of soap; but apparently no shortage of airplanes. Their clothing may be poor, but their steel is not. They are ignorant of what is happening in the outside world, but almost half of the children in their public schools are learning to speak English. Their housing is abominably poor by American standards, but huge apartments are being built all over the length and breadth of the land. The dress of their women is dowdy, but their fashion magazines show styles as modern as those in *Vogue*. In the offices and at work the women make a fetish of modesty in dress, but on the beaches they wear bikinis. Workers are exhorted to exercise individual initiative, but they must submit to authoritarian discipline. People spoke freely to us in the streets and on the beaches and complained about bureaucracy, but free speech as we know it is absent. Stakhanovist competition, urging workers to compete in reaching production goals, is promoted alongside theories of socialist equality. They glorify work and they glorify leisure. Administration of most governmental programs is completely decentralized, but power is firmly held by Moscow. They talk about equality, yet a caste system is evident in salary differentials, vacations, and other such benefits.[1] They extol de-

[1] For example, the vacations of government officials range from two to six weeks, depending on status, with the longer vacations being given to those in the higher ranks.

mocracy and they practice totalitarianism. They decry Western ethical and moral values, yet in their publications it is difficult to find moral standards or goals that are not common to the West, such as love, patriotism, honesty, and family responsibility. The news is controlled, but people read avidly everything published.

Because of these great contrasts in Soviet life, generalizations about the USSR are risky. With full realization, however, of the difficulties, I shall make some general comments about the Soviet Union as a background to an understanding of their social security and related programs.

One of the strongest forces in Soviet life is the idealization of productive work. Love of work is one of the highest goals of Soviet morality, and laboring in the service of the Soviet state is per se ethical, the true vocation of Soviet man.[2] Article 12 of the Soviet Constitution sets forth this objective by stating clearly that "Work is a duty and matter of honor for every able-bodied citizen." This goal has resulted in the development of programs and techniques for employing the aged, the physically handicapped, and others unable to compete with more able-bodied workers. Approximately one third of the inmates in the homes for the aged are working, either part or full time, for wages. Although such work is apparently of a voluntary nature, we met women over eighty years of age who were working—with apparent benefit to themselves financially, physically, and psychologically. The disabled receive special attention. Enterprises are required to employ specified proportions of disabled persons, and producers' cooperatives, manned largely by disabled persons, are encouraged. Social pressures impel all able-bodied persons to work. Since most housewives and mothers work, the day care of children has become an important program.

The Soviet work week is now generally forty-six hours—eight hours for five days and six hours on Saturday. Wage differentials are great. Most clerical workers earn 500 to 600 roubles a month (about $50 to $60),[3] whereas miners and steelworkers earn 2,500 roubles

[2] Herbert Marcuse, *Soviet Marxism—a Critical Analysis* (New York: Columbia University Press, 1958), p. 239.

[3] The official tourist rate of exchange is 10 roubles to a dollar.

or more. There is relatively little unemployment. The employment problem appears to have been solved by "made work." For example, it is not an uncommon sight to observe a modern street-cleaning machine working in the same block with several women wielding big hand brooms.

Most workers are paid on the basis of piecework. The principle of "social competition" based on the early concepts of Stakhanovism encourage the worker to reach quotas and production goals and to exceed the production of his fellow workers. Those who meet quotas receive special bonuses and awards.

Although our team did not make an exhaustive study of economic trends, it is apparent that the USSR is making a Herculean effort to expand production. Everywhere signs and slogans urge the Soviet worker to assist in surpassing the United States. There is little question that the Soviets are making tremendous economic strides. Everywhere new factories are being built, and every year sees more consumer goods available. Our impression was that the USSR is developing a dynamic and expanding economy. We saw evidence to support the report of Allen W. Dulles, head of our Central Intelligence Agency, that during the past seven years Soviet industrial production has grown at a rate almost three times our own.[4] Yet, our observations lead us to believe that the standards of living and of production in the Soviet Union, taken as a whole, are far below those of the United States today.

Everywhere we encountered great ignorance about life outside the Soviet Union. The average Soviet citizen has no concept whatsoever of the very large differential that exists between Soviet living standards and those of the more economically advanced countries outside the Iron Curtain. Information given to the populace is carefully screened. Even speeches of Soviet officials at the United Nations, heard over the radio by people throughout the Western world, frequently are not broadcast in the Soviet Union. We were given a simple explanation of why Soviet citizens are generally not allowed to read foreign publications. It was stated that these contain many errors and falsehoods, but that Soviet publications

[4] Editorial, New York *Times*, April 13, 1959.

do not, since the function of the Communist party, with its vast resources for analysis and research, is to distinguish the true from the false and to permit publication of only that which is true!

Our team came away with a strong impression that the overwhelming majority of the Soviet people have faith in their government and in their future. Even when some voiced criticism, they added that things were better this year than ever before and next year would be even better. The Soviet people are enthusiastic about their progress, and it was our feeling that talk about internal revolution is mere wishful thinking. For the average Soviet citizen sees an ever rising standard of living—more food, more clothing, more housing, better education, higher pay, better pensions, better medical care. All of these are things the people are talking about. We, who have enjoyed the civil liberties of the United States and of other Western countries, find it difficult to understand the lack of concern of the Soviet people over the fact that there is no free speech, no right of assembly, a controlled press, and a complete lack of what we understand are the fundamental personal liberties due an individual in modern society. But we must remember that the Soviet people never had these civil liberties. Never in their history have they had free speech or the right of assembly or free press. Therefore, they do not know the value of these liberties which they have never understood or experienced. They do not miss these civil liberties because they have never had them. It was our feeling that certainly they are not going to protest the lack of these liberties in the near future. Rather will their protests come, if they do, in wanting more and better food, more and better clothing, more and better housing, more and better medical care, more and better social security programs. These are the things they think important. We may disagree and we may look upon our liberties as so important that we would be willing to fight and die for them but, in our opinion, the Soviet people do not. What they look upon as important are the material things, and in these material areas they are making progress.

The emphasis on culture and education has resulted in virtually abolishing illiteracy. Education is avidly pursued. The best minds are going into the natural and physical sciences—fields more re-

warding than the social sciences. Organized religion seems to be gradually dying under a program whereby churches are permitted to remain open but propaganda and official policy are antireligious. Every large community has an opera house, ballet, drama, a symphony orchestra. American jazz is played all over the Soviet Union, but much of it is described as Negro music—which seems to make it more acceptable. The average Soviet citizen, exposed to official propaganda, is firmly convinced that the United States desires a war of annihilation with the Soviet Union, and he fervently hopes for peace.

These observations are merely indicative of a wide variety of impressions we received; they are in no sense complete. Our group left the USSR grateful for the experience of having witnessed the Soviet giant in action on his home ground, and convinced of the importance of our country's policy in promoting cultural exchange missions.

Contrary to popular conception in the United States, the USSR has a widely developed and extensive social security system covering all who work for wages and salaries but excluding, in most respects, collective farmers, who constitute more than one third of the working population. Its basic provisions involve money payments and services in the economic contingencies usually covered under social security plans in other countries with the exception of unemployment. There is no unemployment insurance program and no provision to assist unemployed persons. Thus, the USSR social security programs pay benefits in retirement, on death of the wage earner, and in cases of disability or illness. There are additional rewards for long service to the government and the nation, and special rewards for those engaged in hazardous and difficult employment. As under the United States system of Old-Age, Survivors, and Disability Insurance, pension benefits are paid under a weighted benefit formula so that lower paid workers receive proportionately larger benefits in relation to previous earnings than do the better paid workers.

The entire cost of the Soviet social security program is paid by contributions from the employing enterprises and from general revenues. No contributions are made by the persons covered un-

der the program—a point which is widely publicized by the Soviets but which is of no real financial advantage to the worker in a controlled economy since wages are determined in recognition of this factor.

The cash benefit programs in the USSR are sickness benefits (including short-term industrial injury benefits), maternity benefits, family allowances, and old-age, disability, and survivor pensions (including long-term industrial injury benefits).

The basic premise and foundation of social security in the USSR is founded on Article 120 of the Soviet Constitution, which states:

> Citizens of the USSR have the right to maintenance in old age and also in the case of sickness or disability. This right is ensured by the extensive development of social insurance of industrial, office, and professional workers at state expense, free medical service for the working people, and the provision of a wide network of health resorts for the use of the working people.

The present social security system is based upon the law of 1956. Prior to 1956 the system was a very poor one, compared to that in Western countries and in other Communist countries, such as Czechoslovakia. Benefits were extremely low, not enough to provide even the barest minimum of subsistence.[5] Pension payments were uneven; the majority of pensioners received low pensions while a favored few received higher special or individual pensions out of all proportion to any equitable standard. As a result of these defects, there was considerable criticism. In March, 1956, the Twentieth Congress of the Communist party called for modernization of the social security program to raise benefit levels and to correct certain inequities. Pursuant to such action, the Supreme Soviet established the present system, which is generally well regarded by the Soviet people. In many republics, the social security budget was the largest governmental expenditure. Whether at the level of the district councils, city councils, oblasts, republics, or USSR, social security considerations loomed large in the structure of the economy. For the average worker covered by the system,

[5] Although Soviet publications indicated that general old-age pensions could be as much as 240 roubles a month or up to 330 roubles for dangerous occupations, our team found that the vast majority of the pensions were at the prescribed maximum monthly rate of 210 roubles.

benefits are high in relation to wages. The program appears to be well administered, with a genuine concern for the people's welfare on the part of social security officials.

Old-age, disability, and survivor pensions.—Old-age, disability, and survivor pensions are payable under a detailed and extremely complicated system—a situation, it must be admitted, which exists in most Western countries. Practically all who work for wages are covered, but coverage does not extend to workers on collective farms. Collective farmers must look for assistance to the collective's Mutual Benefit Society. Such societies are maintained by a relatively small contribution from the collective—from one to 2 percent of the income of the collective. Benefits are, therefore, related to the financial status of the individual collective enterprise. Efforts are being made by Soviet officials to develop greater standardization of these programs.

Old-age pensions.—As in other countries, the largest program is the old-age pension. For the average worker, the minimum retirement age is sixty for men and fifty-five for women.[6] Although this appears to be a low retirement age, the population of the USSR above their retirement ages is actually somewhat smaller than that in the United States, based on our minimum retirement ages of sixty-five for men and sixty-two for women. Thus, from a cost-burden standpoint, the Soviet minimum retirement ages are less costly than ours. The situation may change as the population of the Soviet Union grows older.

The length-of-service requirement is generally twenty-five years for men and twenty years for women but is five years less than this for those employed in dangerous work. Pensions are paid in full only upon complete retirement from work, although greatly reduced partial pensions are available if an individual's earnings are not too high.[7] The dollar equivalent amount of the average retire-

[6] For those engaged in "difficult" work, such as many jobs in steel mills, the age is fifty-five for men and fifty for women; and fifty for men and forty-five for women for those engaged in so-called "dangerous" work, such as underground mining.

[7] The retirement test is a very restrictive one as compared to that in the United States. Thus, for general employment, if a worker beyond retirement age makes over 1,000 roubles a month, no pension is paid; if earnings are less than 1,000 roubles, a reduced pension of 150 roubles is payable. This sum is one half of the

ment pension is fairly close to the average amounts paid to single men under the United States program. It is based on the average earnings in the period preceding retirement and does not vary with length of service once the minimum eligibility period has been met (except for a small supplement for very long service). The benefit is a graded one giving 100 percent of pay for those with low earnings, with a minimum of 300 roubles a month ($30 at present rate of exchange—compare this to the amount of $33 in the United States system), down to 50 percent of pay within the prescribed maximum pension of 1,200 roubles a month for those with higher earnings.[8] Small supplements are available for dependents within the maximum. For the average retired worker who receives a pension of around 500 roubles, this constitutes 65 to 70 percent of pay.

There is a variety of special retirement programs for specific groups. Thus, teachers get a pension after twenty-five years of service irrespective of age and receive 40 percent of their salary in addition to other regular earnings.

Disability.—Disability pensions are available under an extremely complicated and complex system. There are eighteen different disability categories. In each category the benefit is determined by a weighted benefit formula, similar to the way in which it is done under the United States system. Small supplements are available for those with dependents and for those requiring an attendant. None of the eighteen different benefit formulas are the same as the formula for old-age pensions, except as to the maximum of 1,200 roubles per month. The disability pensions provide

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minimum payable for full retired persons and less than 25 percent of the average pension. In dangerous employment one half of the pension is paid irrespective of earnings from employment.

[8] The following table sets forth the benefits:

Monthly Earnings in Roubles	*Pensions in Nondangerous Employment Expressed as a Percent of Earnings*	*Minimum Pensions in Roubles*
Up to 350	100	300
350 to 500	85	350
500 to 600	75	425
600 to 800	65	450
800 to 1,000	55	520
1,000 to 2,400	50	550
2,400 and over		1,200

a relatively high percentage of pay for those with low earnings who are permanently and totally disabled, and, conversely, a relatively low percentage of earnings for those only partially disabled who have high wages.[9]

There is a close relationship between determination of disability and programs of rehabilitation and employment. The medical team at the local district social security office (usually consisting of three physicians) must have knowledge of local employment opportunities. If the disabled can work they are placed in regular employment or in a type of sheltered workshop. Throughout the country, also, are research institutes which study the causes of disability and develop materials for the guidance of medical examining commissions and rehabilitation officials. As a result of this emphasis upon work, a majority of those least disabled (Grade 3) are working; probably about 20 percent of those in Grade 2 are

[9] The basic provisions in the disability program are:

a) *Length of service.* If disability is work-connected, there is no length-of-service requirement; if not work-connected, the service requirement depends on age and occupation, varying from one to 20 years.

b) *The three grades of disability:*

Grade 1. Total and permanent disability requiring a constant attendant
Grade 2. Total and permanent disability not requiring a constant attendant
Grade 3. Partial permanent disability

c) *Amount of pensions for work-connected disability:* Pensions are higher for those in difficult or dangerous work.

Grade	*Percent of Wage*	*Minimum in Roubles*	*Maximum in Roubles*
Grade 1	100 percent up to 500 roubles plus 10 percent of remainder	360	1,200
Grade 2	90 percent up to 450 roubles plus 10 percent of remainder	285	900
Grade 3	65 percent up to 400 roubles plus 10 percent of remainder	210	450

d) *Amount of pensions for disability* not *work-connected:*

Grade	*Percent of Wage*	*Minimum in Roubles*	*Maximum in Roubles*
Grade 1	85 percent up to 500 roubles plus 10 percent of remainder	300	900
Grade 2	65 percent up to 450 roubles plus 10 percent of remainder	230	600
Grade 3	45 percent up to 400 roubles plus 10 percent of remainder	160	400

working; and about 8 percent of those in Grade 1 (the most severely disabled) are working.[10]

Survivor pensions.—Survivor pensions are similar to those in the United States except that in relation to old-age or disability pensions the Soviet pensions are much lower. If there are three or more dependents, the pension is the same as for a totally and permanently disabled single worker in Grade 1.

Family allowances.—Family allowances are available to the entire populace, unlike the previously discussed benefits which are not applicable to the peasants on collective farms. However, the scope of these allowances is quite limited as compared to similar systems in other countries, and the amounts of benefits are relatively low. A small lump-sum payment (200 roubles) is made to the mother upon the birth of her third child and increasingly larger payments are made for subsequent births. Monthly payments are made for the fourth child and subsequent children, but only while each such child is between the ages of one and five. Monthly payments are made to unmarried mothers, with the amount thereof depending upon the number of children under twelve years of age. In general, the payments per child are small, averaging only about 7 percent of the average wage in the Soviet Union.[11] It is interesting to note that in spite of these family allowances and the incentives of various medals and awards for large families, fertility in the Soviet Union is relatively low as compared to the United States or some other Western countries. (The crude birth rate is slightly higher than that of the United States, but age-specific fertility is significantly lower.)

Sickness, maternity, and industrial disability.—All workers in commerce, industry, government service, and on government-operated farms have cash sickness benefits available that are, to some extent, like sick leave. In other words, the coverage for this type of protection applies to virtually all workers; the workers in the producers' cooperatives, who in many instances are permanently

[10] These are estimates based upon figures from a few local offices.

[11] For example, monthly payments are as follows:

4th child until 5 years of age	40 roubles
5th child	60 roubles
9th child	125 roubles

partially disabled individuals, are generally covered by the establishment on the same basis as for other workers, as described hereafter. These benefits are payable directly by the employing enterprise. The worker must present a doctor's certificate of illness in order to collect benefits, even for a sickness of as little as one day. Some better-paid workers go after their regular working hours to doctors who have a private practice so as to obtain such certificates for short illnesses (such as a cold) that do not require formal medical care at a clinic. This necessitates spending less time than would be entailed if they went to a clinic.

The benefits are payable without a waiting period and for an unlimited duration except that, as a practical matter, after two to four months of continued sickness an individual is transferred to the disability pension roll. The benefits are thus payable on a daily basis. The benefits are related to the person's average earnings in his last two months of employment.[12]

Cash maternity benefits.—Upon birth of a child the mother receives 300 roubles for purchase of a layette and sixteen weeks leave with benefits.[13]

Short-term work-connected injury and disease cash benefits.—For work-connected injury and disease the benefit is 100 percent of "recent" earnings and begins on the first day. The benefit has no fixed duration but is converted to a disability pension after two to four months.

The social services.—Many of the social programs of the USSR resemble the programs of the United States. Day nurseries, recrea-

[12]

Years of Service with Single Enterprise	*Benefit as Percent of Earnings*
Under 3	50
3 to 5	60
5 to 8	70
8 to 12	80
12 or more	90

[13] The amount of the benefit as related to "recent" earnings is as follows:

YEARS OF SERVICE		BENEFIT AS PERCENT OF PAY	
Continuous with Present Enterprise	*Total with all Enterprise*	*First 20 Days*	*Remainder of Period*
Under 1		66⅔	66⅔
1 to 2		66⅔	100
2 or more	Under 3	75	100
2 or more	3 or more	100	100

tion centers, camps, and other activities are organized along lines with which we are familiar. A great difference between the two countries stems from the Soviet rejection of psychoanalysis as a valid technique. Although there are a large number of Soviet psychiatrists, they look upon psychoanalysis as a capitalist manifestation and reject its emphasis on the individual and on the subconscious. Psychotherapy in the USSR is based on suggestion and counseling, a widespread use of hypnosis, and reeducation on the "conscious" level.[14] Without going into detail, Soviet psychiatry may be characterized as follows: [15]

1. It is an ultraconservative approach. To cite only one example, two treatment methods in American psychiatry which lie at extreme opposite poles, namely, prefrontal lobotomy and psychoanalysis, are either officially banned or unofficially condemned.

2. Emphasis is on physiological considerations, materialistic approaches, and Pavlovian concepts.

3. Soviet psychiatry is not hospital-oriented. There is great emphasis on outpatient treatment.

4. The Soviet psychiatrist is research-minded, and a great deal of research is underway.

It is interesting to note that none of the official teams or visitors to the USSR has been able to secure any reliable over-all statistics concerning mental illness.

The rejection of psychoanalysis means that social casework, as we know it in the United States, is either not understood or rejected as a valid technique. Although persons called "social workers" are employed by social security offices, and the term is applied also to elected factory representatives who visit families, such persons are untrained and resemble the old volunteer friendly visitor of the United States social agencies of fifty years ago.

Nevertheless, a large network of social services does exist, and Soviet social welfare programs encompass all aspects and hazards of life and are administered as an integral part of the political, economic, and social system. Social services are the responsibility

[14] Z. M. Lebenson, "Impressions of Soviet Psychiatry," *A.M.A. Archives of Neurology and Psychiatry*, LXXX (1958), 735–51, 741.
[15] *Ibid.*, p. 750.

of the USSR Ministries of Health and Education; the various Republic Ministries of Health, Education, and Social Security; the trade unions, both locally and nationwide; and other governmental organizations at the various levels of the Soviet government.

Medical care.—Medical care is provided by the Ministry of Health, which operates the hospitals, clinics, and other medical care facilities and is responsible for the usual medical treatment. The USSR has no counterpart of the medical social worker in the United States. Doctors are more numerous than in the United States. In the cities, the ratio of physicians is 3 per 1,000 population, whereas in the United States the ratio is 1 to 2 per 1,000. When a person needs primarily custodial care, as in cases of chronic mental illness, serious disability, or other long-term disorders, he is transferred to an institution of the Ministry of Social Security.

Day care.—The Ministry of Health also operates nurseries for the care of children under the age of four.[16] These crèches, or day-care centers, are usually established near the places where the mothers work. Approximately 50 percent of all children under four are in such centers. Although housed in buildings inferior to many buildings housing day nurseries in this country, the average nursery in the Soviet Union is in most other respects superior to the average nursery in the United States. The equipment is excellent. The ratio of employees is high—one employee to 2.5 children. Employees are well-trained teachers, nurses, or physicians. Each nursery has at least one full-time physician.

The Ministry of Education, in addition to being responsible for elementary and advanced education, operates kindergartens for children from age four until age seven, when they are ready for elementary schools. These kindergartens, like the day nurseries, have the dual purposes of enabling mothers to work and of educating—or perhaps rather indoctrinating—the child in the way of Communist life. Schoolteachers are held responsible for seeing that the children "learn and benefit" from the educational system. Accordingly, teachers to some extent become child welfare or social workers in our sense since they are required to pay close attention

[16] There are still some nurseries operated by individual industries or enterprises. However, the plan is to integrate all of them into the Ministry of Health.

to the progress of the children, arrange conferences with parents, and also visit the homes. The schools may recommend to the local government that children be removed from the care of their parents and placed in adoptive homes.

Other broad areas of social services carried out by the Soviet government include summer camps for children and youth and various recreational clubs (called "pioneer clubs") in after-school hours that are in addition to normal recreational and cultural activities. Activities for adults are largely concentrated in facilities for recreation and education in individual business enterprises, and at so-called "houses of culture" which are established through funds collected by the trade unions. The latter provide group recreational activities that include gymnasium and sport activities, libraries, game rooms, and facilities for developing group talent in art, music, and drama. The houses of culture are generally established by particular factory trade union groups, although other people in the locality may attend. There are some special houses of culture for particular groups, such as the deaf and dumb.

The trade unions provide funds for certain welfare activities, in large part from the social security contributions collected from employing enterprises and agencies (the remainder of such contributions are turned over to the various Ministries of Social Security to meet part of the cost of the pension system). The trade unions furnish individuals with part or all of the cost of short-term (usually thirty-day) rest home and sanitarium care, as well as having some funds available for lump-sum payments for medicines not provided free by the Ministry of Health, for transportation expenses, and for burial costs.

The trade union representatives provide a considerable amount of personal information and counseling services such as, for example, assisting workers in obtaining their social security benefits. These representatives also give advice to workers who are not working as hard and efficiently as they should be and are thus not producing in accordance with the group goal. Counseling on problems of family and personal life is furnished by the trade union representatives on an informal basis.

Homes for the aged are found throughout the Soviet Union.

Physical facilities vary from new and adequate buildings to the most inadequate. They are well staffed, with one employee to every three persons. Each home has one or more full-time physicians, frequently trained in gerontology. A substantial percentage of inmates work for wages on a voluntary basis.

Public assistance.—Even in a collectivist society situations arise where financial aid or relief is necessary. It was therefore surprising to learn that the USSR has no regularly organized system of public assistance such as is found in most Western countries. Financial assistance programs on an informal basis are available through the social security officials, for persons receiving pensions, or through the mutual aid societies of the collective farms. Financial assistance is purely a supplementary program of lump-sum payments to meet a specific, usually nonrecurring need, such as rest home and sanatoria expenses, payment for medicines, transportation to rest homes, or burial costs. The determination of need for such payments is left to the trade union committee in the enterprises, the local social security officials for persons not working, and the mutual aid societies of the collective farms.

Savings.—The purpose of a social security program is to provide a form of economic security. In addition to social insurance, other institutions assist in providing economic security. Two of these, namely, savings and insurance, are in widespread use in the Soviet Union. Soviet workers can live within their incomes, although not on a scale that we would consider to be comfortable living. As a result, private savings have grown materially.[17] There are approximately fifty thousand savings banks which pay 2 percent interest on short-term deposits and 3 percent on long-term deposits. There are approximately forty-three million depositors. We visited several of these banks which are operated by the Ministry of Finance.

Private insurance.—Most persons are surprised to learn that the Soviet Union has an extensive system of private insurance similar to insurance programs of other countries. Much of this insurance is sold individually on a voluntary basis.

[17] Indicative of recent growth is the increase in depositors from 30 million in 1956 to 43 million in 1958; total deposits in 1956 were 53.8 billion roubles as compared with 80 billion in 1958.

The insurance program is owned and operated by a government organization called "Gosstrakh" (which stands for "Government Insurance"). Gosstrakh, a constituent agency of the Ministry of Finance, handles a wide variety of insurance—casualty, fire, and life. There is also a marine insurance organization, with offices outside the Soviet Union. Although an outsider can see many differences, the operations of Gosstrakh resemble those of a typical insurance company in the United States with reference to policy provisions, benefits, rates, and with salesmen paid on a commission basis.

Training.—With the emphasis in the Soviet Union on training of all types, it is understandable that in the field of social security much time and attention should be devoted to training. No specific curriculum in the universities is available for social security or social welfare officials. In social security, personnel is recruited from among economists, lawyers, and others. However, an extensive system of in-service training has been developed; there is a liberal educational leave policy; refresher courses; regular "training letters" setting forth subject matter and methods of teaching; and institutions where workers live in during their refresher courses. These efforts have resulted in apparently well-trained and competent personnel.

It is a matter of interest to persons in public welfare in the United States, who are worried about staff turnover, to learn that in the cities of the USSR there is a turnover of approximately 25 percent of the social security staff each year.

Financing and administration of social security programs.—Social security programs are financed both from the general USSR budget and from a payroll tax of 4.4 percent to 9 percent of wages, the higher rates applying in the more dangerous industries.

As in most government programs, the administration of social security has been almost completely decentralized from the All-Union level to the fifteen republics. In each republic there is a Minister of Social Security. This extremely important official administers the various pensions, family allowances, institutions for the aged, children, and disabled, the manufacture and distribution of prosthetic appliances, and a variety of services.

The trade unions, which are in effect government bureaus, administer temporary disability and maternity benefits, burial allowances, health resorts, camps, and houses of culture.

Since the Soviet economy is a cash economy, certain pensions, such as old-age pensions, are paid in cash by the postman; family allowances are paid in cash by the savings banks.

In evaluating the social security and social welfare programs of the USSR it is difficult to arrive at simple or dogmatic judgments. Even more difficult is the comparison with other countries which have different goals, different history, and different standards of living. We were, however, impressed with the growth of, and improvement in, social security since 1956; with the emphasis on research; with the elaborate training procedures; with the emphasis on work and its influence on programs of disability and rehabilitation; and with the absence of many social services which we have developed in the United States.

We believe that we have learned much from our study of social security in the Soviet Union. It is trite, but increasingly true, that every day the world is becoming smaller. Our team was in Moscow only a few hours after leaving New York. In such a world, the social programs of any major nation are bound to affect, at least indirectly, the programs of our own country. Through international organizations such as the Economic and Social Commission of the United Nations, the International Labor Organization, the International Social Security Association, the United Nations International Children's Emergency Fund, the World Health Organization, and many others, action is taken which influences the activities of all nations, both great and small. The beginnings of uniform definitions of terms to assist in comparability of reports and statistics, the more accurate reporting of developments in each country, the intense interest of underdeveloped nations in the social security programs of the industrial nations, the issuance by international bodies of social security literature which becomes study material for students—all these and more indicate the need to understand the system in that country which today stands as the most important competitor of the United States in the world market of ideas and ideals. In learning firsthand about Soviet so-

cial security activities, we can better understand the positions taken by Soviet representatives in international meetings where social security and related matters are discussed.

I hope that these official exchanges between the United States and the USSR will continue, and that through them as well as through the travel of individuals we shall learn more about the complex programs which I have merely touched upon. These exchanges can be instrumental in the lessening of tensions between the two countries. We may not like their system, but it is here, and we must understand it because we have to live with it.

Appendix A: Program

THE MAJOR FUNCTION of the National Conference on Social Welfare (NCSW) is to provide a dynamic educational forum for the critical examination of basic welfare problems and issues.

Programs of the Annual Forums are divided into two parts: (1) the General Sessions and the meetings of the section and common services committees, all of which are arranged by the NCSW Program Committee; and (2) meetings which are arranged by the associate and special groups affiliated with the NCSW.

In addition to arranging these meetings, associate and special groups participate in the over-all planning of the Annual Forum programs.

In order that the NCSW may continue to provide a democratic forum in which all points of view are represented, it is prohibited by its Constitution from taking positions on social issues. Individuals appearing on Annual Forum programs speak for themselves and have no authority to use the name of the NCSW in any way which would imply that the organization has participated in or endorsed their statements or positions.

Theme: Social Welfare: New Knowledge—Consequences for People

SUNDAY, MAY 24

2:00 P.M.–3:00 P.M.

Orientation Session for Newcomers

Speakers: Joseph P. Anderson, Executive Director, National Association of Social Workers, New York; Ruth M. Williams, Assistant Executive Secretary, National Conference on Social Welfare, New York office

3:15 P.M.–3:45 P.M.

Orientation Session for Foreign Visitors

8:00 P.M.

Opening General Session. New Knowledge—Consequences for People

Presiding: Robert H. MacRae, Executive Director, Welfare Coun-

cil of Metropolitan Chicago; President, National Conference on Social Welfare

Musical program by San Francisco Municipal Chorus

Invocation by Boy Scout troop from California School for the Deaf

Greetings from Mrs. Rudolph Arfsten, Vice Chairman, Volunteers of the San Francisco Chapter of the American Red Cross; Chairman, San Francisco Sponsoring Committee for the 86th Annual Forum

Greetings from the City of San Francisco by Mayor George Christopher

Greetings from the State of California by John M. Wedemeyer, Director, California State Department of Social Welfare

Presidential Address

Robert H. MacRae

MONDAY, MAY 25

9:15 A.M.–10:45 A.M.

General Session. The Future of Public Assistance

Presiding: Wilbur J. Cohen, Professor of Public Welfare Administration, School of Social Work, University of Michigan, Ann Arbor; member, Executive Committee, National Conference on Social Welfare

Introduction of members of NCSW Program Committee and Committee on Combined Associate Group Meetings

Speaker: Ellen Winston, Commissioner, North Carolina State Board of Public Welfare, Raleigh

11:15 A.M.–12:45 P.M.

Section I. Services to Individuals and Families

GROUP MEETING 1. RECRUITMENT OF ADOPTIVE HOMES FOR THE HARD-TO-PLACE

Presiding: Clyde Getz, Executive Director, Children's Home Society of California, Los Angeles

Panel members: Walter Heath, Director, Los Angeles County Bureau of Adoptions; Helen Fradkin, Consultant, Child Welfare League of America, New York; Michael Schapiro, Area Supervisor, Children's Home Society of California, and former Executive Director, MARCH; Rosalind Giles, Director, Child Welfare Division, Texas State Department of Public Welfare, Austin

Floor discussion

GROUP MEETING 2. A NEW LOOK AT SERVICES FOR THE AGED

Presiding: John R. May, Executive Director, San Francisco Foundation

Panel members: Louis Kuplan, Executive Secretary, California Citizens Advisory Committee on Aging; President, American Gerontological Society; President-elect, International Association of Gerontology, Sacramento, Calif.; Wilbur J. Cohen, Professor of Public Welfare Administration, School of Social Work, University of Michigan, Ann Arbor; Ellen Winston, Commissioner, North Carolina State Board of Public Welfare, Raleigh

GROUP MEETING 3. OUT-OF-HOME PLACEMENT OF THE DISTURBED CHILD

Presiding: Lucile Kennedy, Chief, Division of Child Welfare, California State Department of Social Welfare, Sacramento

Speaker: George L. Perkins, M.D., Chicago

The Foster Home as a Resource

Speaker: James R. Mann, Executive Director, Children's Foster Care Services, Oakland, Calif.

A Comprehensive Program for Continued Care and After-Care of Children Discharged from a Residential Treatment Center

Speaker: Herbert Rosen, Acting Director of Social Service, Wiltwyk School for Boys, New York

Floor discussion

GROUP MEETING 4. THE ROLE OF THE SOCIAL SERVICES IN THE OVER-ALL PROGRAM FOR THE MENTALLY RETARDED AND THEIR FAMILIES

Presiding: Gunnar Dybwad, Executive Director, National Association for Retarded Children, New York

Speakers: Mrs. Nellie D. Stone, Clinic Director, Guidance Clinic for the Retarded, Essex Unit, New Jersey Association for Retarded Children, East Orange; Anne Frankel, caseworker, Family Service of San Francisco

GROUP MEETING 5. WHAT DOES REHABILITATION MEAN IN PUBLIC ASSISTANCE?

Presiding: Frederic Kriete, M.D., Deputy Director, California State Department of Public Health, Berkeley

Speakers: Harold E. Simmons, Superintendent, Social Services Division, San Mateo County Department of Public Health and Welfare, San Mateo, Calif.

Elsbeth Kahn, Director, Medical Social Service, Rancho Los Amigos Hospital, Downey, Calif.

Leon Lewis, M.D., Director, Respiratory and Rehabilitation Center, Fairmont Hospital, San Leandro, Calif.

GROUP MEETING 6. SOCIAL SERVICE RESPONSIBILITY IN PREVENTION, TREATMENT, AND CONTROL OF JUVENILE DELINQUENCY

Presiding: Milton Chernin, Dean, School of Social Welfare, University of California, Berkeley

Speaker: Maurice O. Hunt, Chief, Bureau of Child Welfare, Maryland State Department of Public Welfare, Baltimore
Discussants: Heman G. Stark, Director, California Youth Authority, Sacramento; Ralph M. Kramer, Executive Director, West Contra Costa Community Chest and Community Welfare Council, Richmond, Calif.

GROUP MEETING 7. NEW DEVELOPMENTS IN SERVICES OF VOLUNTEERS IN PUBLIC WELFARE

Presiding: Eva Hance, Director of Social Planning, San Francisco United Community Fund

Volunteers in a Total Treatment Program
Speaker: E. H. Nordby, Director, Crystal Spring Home, San Mateo County Department of Public Health and Welfare, San Mateo, Calif.

Citizen Interpretation and Support of Public Agency Services
Speaker: Donald Fibush, Manager, Prudential Life Insurance Company, Concord, Calif.; member, Citizens' Advisory Committee on Adoption to the Contra Costa County Social Service Department, Martinez, Calif.

The Administrative Framework of a Volunteer Program in a Public Welfare Department
Speaker: Marjorie R. Thaxter, Supervisor of Volunteer Services, U.S. Department of Public Welfare, Washington, D.C.

Floor discussion

GROUP MEETING 8. THE NATURE OF SERVICES IN PUBLIC ASSISTANCE
Presiding: Andrew F. Juras, Assistant Administrator, Oregon State Public Welfare Commission, Portland
Speaker: Charles I. Schottland, Dean, Florence Heller School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass.
Discussants: Jacob P. Kahn, M.D., Acting Associate Professor of Psychiatry, Stanford University Medical School, and Psychiatric Consultant, San Francisco Public Welfare Department; Ralph L. Wilson, Director, San Luis Obispo County Welfare Department, and President, County Welfare Directors Association of California

Section II. Services to Groups and Individuals in Groups

The Impact of Social Change on Social Welfare. Eduard C. Lindeman Memorial Lecture
Presiding: Alan F. Klein, Graduate School of Social Work, University of Pittsburgh

Speaker: Seymour M. Lipset, Department of Sociology and Social Institutions, University of California, Berkeley
Discussant: Alan F. Klein
Floor discussion

Section III. Services to Agencies and Communities

GROUP MEETING 1. USE OF PUBLIC FUNDS BY VOLUNTARY AGENCIES
Presiding: William L. Mitchell, Commissioner, Social Security Administration, U.S. Department of Health, Education, and Welfare, Washington, D.C.
Speaker: Arlien Johnson, former Dean, School of Social Work, University of Southern California, Los Angeles
Discussant: Laurin Hyde, President, Laurin Hyde Associates, New York

GROUP MEETING 2. COMMUNITY IMPLICATIONS OF DEVELOPMENTS IN PUBLIC HOUSING
Presiding: Mrs. Arnold Rue, Chairman, Redevelopment Agency of Stockton, Calif.
Speakers: Marie McGuire, Executive Director, Housing Authority of San Antonio, Texas
Helen Hall, Director, Henry Street Settlement, New York; Consultant on Social Policy to the New York City Housing Authority

Committee on Audio-visual Aids. Rehabilitation of a Child—the Team Approach
Presiding: Mildred Alexander, School of Social Welfare, University of California, Berkeley
"Hannah Means Grace." Hadassah, 65 East 52d Street, New York 22, N.Y.

1:15 P.M.–2:00 P.M.

Committee on Audio-visual Aids
"One Day's Poison." National Film Board of Canada, 680 Fifth Avenue, New York 19, N.Y.

2:00 P.M.–3:30 P.M.

Committee on Planning Meetings in Social Welfare. Identification and Purpose Served by Different Types of Meetings
Presiding: Mrs. Freda Burnside, Field Consultant, Family Service Association of America, Western Region, San Francisco
Speaker: Mrs. Eva Schindler–Rainman, School of Social Welfare, University of California, Los Angeles
Floor discussion

Committee on Public Relations

GROUP MEETING 1. ATTITUDES TOWARD THE SOCIAL WORK PROFESSION

Presiding: Heman G. Stark, Director, California Youth Authority, Sacramento

Speaker: Melvin A. Glasser, Executive Vice President, National Foundation, New York

Discussants: Jack Allen, San Francisco *Examiner;* North Baker, public relations consultant, San Francisco

Floor discussion

GROUP MEETING 2. (CO-SPONSORING GROUP: COMMITTEE ON AUDIO-VISUAL AIDS)

Films for Public Relations

Presiding: John S. Blum, Executive Director, San Mateo County Heart Association, San Mateo, Calif.

"You're It," Girl Scouts of the U.S.A., 830 Third Avenue, New York 22, N.Y.

Panel members: Leah Parker, Girl Scouts of the U.S.A., New York; Harold Weiner, Executive Director, National Publicity Council for Health and Welfare Services, New York

Floor discussion

Committee on Social Research

GROUP MEETING 1. INTENSIVE CASEWORK IN PUBLIC ASSISTANCE

Presiding: Joseph A. Spangler, Administrative Officer, California Youth Authority

Speaker: S. A. Dombroski, Supervisor, Intensive Casework Division, Milwaukee County Department of Public Welfare, Milwaukee

Discussant: Karl Rehfeld, Supervisor, Intensive Casework Unit, Lake County Department of Public Welfare, Gary, Ind.

GROUP MEETING 2. SOCIAL WORK CURRICULUM STUDY

Presiding: Maurice B. Hamovitch, School of Social Work, University of Southern California, Los Angeles

Speaker: Irving Weissman, School of Social Work, Tulane University, New Orleans; formerly on the staff of the Curriculum Study, Council on Social Work Education

GROUP MEETING 3. ISSUES IN COMMUNITY WELFARE RESEARCH

Presiding: Howard F. Gustafson, Executive Director, Health and Welfare Council of Indianapolis and Marion County

Discussants: Genevieve W. Carter, Director, Program Division, Welfare Federation of Los Angeles Area; Robert F. Fenley, Di-

rector, Personnel Department, United Community Funds and Councils of America, New York; Ernest F. Witte, Executive Director, Council on Social Work Education, New York

Committee on Audio-visual Aids. (Joint session with Committee on Public Relations—Group Meeting 2.)
Films for public relations

2:15 P.M.–5:00 P.M.

Special Meeting on Financial Problems of Industrial Employees

Financial Problems of Industrial Employees
Discussion leader: Pete Zidnak, Associate Professor, Industrial Relations Institute, San Jose College, San Jose, Calif.
Discussants: George D. Nickel, Western Public Relations Director, Beneficial Management Corp., Arcadia, Calif.; Dave Soash, Director, Employer-Employee Relations, Merchants and Manufacturers Association, Los Angeles; H. A. R. Carleton, Assistant General Manager, Welfare Federation of Los Angeles Area; Giles S. Hall, Jr., Personnel Director, Consolidated Electrodynamics Corp., Pasadena, Calif.; Roland Jones, Director of Industrial Relations, Carnation Milk Co., Los Angeles; Mary Jo Elm, personnel interviewer, Bank of America, Los Angeles; John Wolfe, Director of Industrial Relations, Ford Motor Co., Milpitis, Calif.; H. W. Bissell, Personnel Manager, Lockheed Aircraft Corp., Sunnyvale, Calif.; John Zuckerman, Personnel Manager, Ampoy Corp., Redwood City, Calif.; June Dunbar, counselor, Hughes Research Laboratories, Culver City, Calif.

4:00 P.M.–5:30 P.M.

Committee on Planning Meetings in Social Welfare. (Co-sponsoring group: Committee on Audio-Visual Aids)

Using a Play at Various Types of Meetings
Presiding: Alfred V. Taylor, Director, Public Relations Service, Family Service Association of America, New York
"Broken Circle," one-act play by Nora Stirling. Family Service Association of America, 215 Fourth Avenue, New York 3, N.Y.
Play director: Mrs. Anna Marie Long, Executive Director, Travelers Aid Society of San Francisco
Panel chairman: David Crystal, Executive Director, Jewish Family Service Agency, San Francisco
Panel members: A. D. Buchmueller, Executive Director, Child Study Association of America, New York; Mrs. Gertrude Leyen-

decker, Assistant for Professional Education, Division of Family Services, Community Service Society of New York; Robert E. Case, Executive Director, Family Service of Pasadena, Pasadena, Calif.

Section I. Services to Individuals and Families

Is Prevention Possible? Eduard C. Lindeman Memorial Lecture
Presiding: Ronald H. Born, Director of Public Welfare, City and County of San Francisco; Chairman of Section I
Speaker: Bradley Buell, Executive Director, Community Research Associates, New York

Section II. Services to Groups and Individuals in Groups

GROUP MEETING 1. THE IMPACT OF SOCIAL CHANGE AND SOCIAL STRUCTURE ON THE ADMINISTRATION OF GROUP SERVICE AGENCIES
Presiding: Emeric Kurtagh, Executive Director, Neighborhood Services Organization, Detroit
Speaker: Sanford Solender, Director, Jewish Centers Division, National Jewish Welfare Board, New York
Discussant: Emeric Kurtagh
Floor discussion

GROUP MEETING 2. ACHIEVING INDIVIDUAL CHANGE THROUGH GROUP SERVICES
Presiding: Mary S. Buchtel, Executive Director, YWCA, San Francisco
Speakers: Alan F. Klein, Graduate School of Social Work, University of Pittsburgh
Howard W. Polsky, Hawthorne Cedar Knolls School, Hawthorne, N.Y.
Floor discussion

GROUP MEETING 3. MEETING COMMUNITY CONFLICT THROUGH GROUP SERVICES
Presiding: Gladys Ryland, field staff, Western Region, National Board of the YWCA, New York
Speakers: Nelson C. Jackson, Associate Director, National Urban League, New York
Evelio Grillo, Community Relations Consultant, Recreation Department, Oakland, Calif.
Floor discussion

GROUP MEETING 4. GROUP WORK—PERSPECTIVES AND CAREER PATTERNS
Presiding: Margaret Berry, Executive Director, National Federation of Settlements and Neighborhood Centers, New York

Speaker: Robert D. Vinter, Jr., Associate Professor of Social Work and Lecturer in Sociology, University of Michigan, Ann Arbor
Discussant: Margaret Berry
Floor discussion

Section III. Services to Agencies and Communities

GROUP MEETING 1. PLANNING SERVICES FOR THE SMALL COMMUNITY
Presiding: Mrs. Jackson Chance, Executive Director, Rosenberg Foundation, San Francisco
Speaker: Reginald Robinson, Director, Task Force on Community Resources, Joint Commission on Mental Illness and Health, Cambridge, Mass.
Discussant: Jack Stumpf, Executive Director, San Bernardino County Council of Community Services, California

GROUP MEETING 2. SOCIAL SERVICE EXCHANGES—YES OR NO
Presiding: Edgar N. Brown, Executive Director, Community Welfare Council, San Diego, Calif.
Discussants: Yvonne Giroux, District Director, San Fernando Valley Office, Family Service of Los Angeles, Van Nuys, Calif.; William H. Ireland, Executive Director, Health and Welfare Council, Seattle
Floor discussion

Committee on Audio-visual Aids. (Joint Session with Committee on Planning Meetings in Social Welfare)
Using a Play at Various Types of Meetings

8:30 P.M.

General Session. Are We Spending Enough for Social Welfare?
Presiding: Clark W. Blackburn, member, National Conference on Social Welfare Executive Committee
Invocation by the Very Reverend Julian Bartlett, Dean of Grace Cathedral, Episcopal Diocese of California
Introduction of Past Presidents and members of Executive Committee of the National Conference on Social Welfare
Recognition of individuals and agencies who have completed fifty years of membership in the National Conference
Presentation of National Conference Awards for outstanding contributions to social welfare
Speaker: Mrs. Ida Merriam, Director of Program Research, Social Security Administration, U.S. Department of Health, Education, and Welfare, Washington, D.C.

10:00 P.M.

Conference Reception

TUESDAY, MAY 26

9:15 A.M.–10:45 A.M.

Combined Associate Group Meeting. Aging in Today's World
Presiding: Margaret Whyte, Executive Secretary, Governor's Council on Aging, Olympia, Wash.
Effect of Aging in Modern Society
Speaker: Leo W. Simmons, Professor of Sociology, Yale University, New Haven, Conn.
The Challenge to the Organization of Welfare Services
Speaker: Thomas B. Sherrard, School of Social Service Administration, University of Chicago

Combined Associate Group Meeting. Family Life Education
Presiding: Bertram H. Gold, Executive Director, Jewish Centers Association, Los Angeles
Perspectives on Family Life Education
Speaker: A. D. Buchmueller, Executive Director, Child Study Association of America, New York
Training for Work in Family Life Education
Speaker: Mrs. Aline B. Auerbach, Director, Parent Group Education Department, Child Study Association of America, New York
Floor discussion

Combined Associate Group Meeting. Serving the Serviceman and Seaman
Presiding: Genevieve Gabower, social worker, U.S. Naval Hospital, Bethesda, Md.
Serving Members of Our Peacetime Armed Forces, Their Families, and Our Seamen at Home and Abroad
Speaker: Charles I. Schottland, Dean, Florence Heller School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass.
The Contribution of Social Welfare—Casework
Speaker: Charles F. Stoughton, Director of Home Service, American National Red Cross, San Francisco
The Contribution of Social Welfare—Group Work
Speaker: Moe Hoffman, Washington Representative, National Jewish Welfare Board
The Contribution of Social Welfare—Community Organization

Speaker: Austin J. Welch, Director of Personnel, United Service Organizations, New York

Floor discussion

Combined Associate Group Meeting. People, Housing, and Social Work

Presiding: Murray B. Meld, Welfare Planning Council, Los Angeles

Public Housing: a Promise and/or Fulfillment

Speaker: E. Morton Schaffran, Deputy Executive Director, Marin County Housing Authority and Redevelopment Agency, Marin City, Calif.

The Social Welfare Responsibilities for Relocation of Displaced Families

Speaker: Reginald A. Johnson, Director of Housing Activities, National Urban League, New York

Citizen Participation in Urban Renewal

Speaker: Fern M. Colborn, Social Action Secretary, National Federation of Settlements and Neighborhood Centers, New York

Floor discussion

Combined Associate Group Meeting. Understanding Group Dynamics in the Learning Process

Presiding: Charlotte Johnson, Assistant National Director, Disaster Services, American Red Cross, Washington, D.C.

Speaker: Gordon Hearn, Associate Professor of Social Welfare and Assistant Dean of Students, University of California, Berkeley

Discussants: Mrs. Caroline Walsh, Manager, Riverside Chapter, American Red Cross, Riverside, Calif.; Mrs. Freda Burnside, Field Consultant, Western Regional Office, Family Service Association of America, San Francisco

Combined Associate Group Meeting. Social Services to Former Mental Patients

Presiding: Portia Bell Hume, Deputy Director, Community Services, California State Department of Mental Hygiene, Berkeley

Speakers: Merton Trast, Social Service Consultant, Kansas State Department of Social Welfare, Topeka

Mrs. Esther Marcus, Jewish Family Service, New York

Raymond V. Craig, Mental Health Consultant in Social Work, Regional Office, U.S. Department of Health, Education and Welfare, San Francisco

Floor discussion

Combined Associate Group Meeting. The 1960 White House Conference on Children and Youth

Presiding: Mrs. Rollin Brown, Los Angeles; chairman, President's

National Committee, 1960 White House Conference on Children and Youth

Speakers: Mrs. Katherine B. Oettinger, Chief, Children's Bureau, Social Security Administration, Washington, D.C., Secretary, President's National Committee, 1960 White House Conference on Children and Youth

Ephraim R. Gomberg, Director, 1960 White House Conference on Children and Youth, Washington, D.C.

Discussants: Robert E. Bondy, Director, National Social Welfare Assembly, New York, and Chairman, Council of National Organizations on Children and Youth; Donald S. Howard, Dean, School of Social Welfare, University of California, Los Angeles, and Chairman, National Council of State Committees

Committee on Audio-visual Aids. Human Relations

"The Golden Door." Dynamic Films, Inc., 405 Park Avenue, New York 22, N.Y.

"Small Explosion." American Jewish Committee, 386 Fourth Avenue, New York 16, N.Y.

Floor discussion

11:15 A.M.–12:45 P.M.

Combined Associate Group Meeting. Aging in Today's World

Presiding: Margaret Whyte, Executive Secretary, Governor's Council on Aging, Olympia, Wash.

A Model of Community Services for the Aging

Speaker: Mrs. Geneva Mathiasen, Executive Secretary, National Committee on Aging, National Social Welfare Assembly, New York

The 1961 White House Conference on Aging

Speaker: William Fitch, Director, Special Staff on Aging, U.S. Department of Health, Education, and Welfare, Washington, D.C.

Combined Associate Group Meeting. Community Responsibility, Planning and Action to Provide Jobs for Hard-to-place Youth

Presiding: Roy Sorenson, General Secretary, YMCA, San Francisco

Speaker: Eli E. Cohen, Executive Secretary, National Child Labor Committee, New York

Discussants: Charlotte D. Elmott, Director of Special Guidance Projects, Santa Barbara City Schools, Santa Barbara, Calif.; Robert Hill, State Supervisor, Counseling and Youth Employment, California State Department of Employment, Sacramento; Mrs. Sylvia Nachmani, Chief Social Service Worker, Institute for Crippled and Disabled, New York

Floor discussion

Combined Associate Group Meeting. Family Life Education

Presiding: Bertram H. Gold, Executive Director, Jewish Centers Association, Los Angeles

Family Life Education in the Casework Setting

Speaker: Norman Paget, Executive Director, Family Service Agency, San Bernardino, Calif.

Family Life Education in the Group Work Setting

Speaker: Margaret Mudgett, Executive Director, Neighborhood Youth Association, Los Angeles

Family Life Education in the Community Organization Setting

Speaker: Jack Stumpf, Executive Director, San Bernardino County Council of Community Services, Calif.

Family Life Education in the Formal Education Setting

Speaker: Sybil Richardson, Associate Professor of Education, San Fernando Valley State College, Northridge, Calif.

Combined Associate Group Meeting. New Knowledge about Mentally Retarded

Presiding: Leo F. Cain, Vice President, San Francisco State College

Speakers: Willard R. Centerwall, M.D., Department of Pediatrics, College of Medical Evangelists, Los Angeles

Alfred H. Katz, M.D., Division of Social Welfare in Medicine, Department of Preventive Medicine and Public Health, University of California School of Medicine, Los Angeles

Mortimer Garrison, Research Specialist in Mental Retardation, Children's Bureau, U.S. Department of Health, Education and Welfare, Washington, D.C.

Floor discussion

Combined Associate Group Meeting. Social Work Training around the World

Presiding: Mrs. Elisabeth Shirley Enochs, International Service, Social Security Administration, U.S. Department of Health, Education and Welfare, Washington, D.C.

Speaker: Mrs. Katherine A. Kendall, Associate Director, Council on Social Work Education, New York

Panel members: Kenneth Murase, doctoral candidate, New York School of Social Work, Columbia University, New York

Discussants: Aura Noemi Aguirre, Panama; Ahmed Manzoruddin, Pakistan

Committee on Audio-visual Aids. Problems of Former Mental Patients in Re-entering the Community

Presiding: J. Gil Marquis, Executive Director, San Francisco Association for Mental Health

"Bitter Welcome." Mental Health Film Board, 267 West 25th Street, New York, N.Y.

"A New Chance." Mental Health Materials Center, 104 East 25th Street, New York 10, N.Y.

Discussants: John Gussen, M.D., Assistant Professor of Psychiatry, Medical School, University of California, Berkeley; J. J. Ploscowe, Regional Supervisor, Bureau of Social Work, California State Department of Mental Hygiene, Sacramento

Floor discussion

1:15 P.M.–2:00 P.M.

Committee on Audio-visual Aids.

"Tell Me Where It Hurts." Hadassah, 65 East 52d Street, New York 22, N.Y.

2:00 P.M.–3:30 P.M.

Committee on Audio-visual Aids. Family Life Education

Presiding: Mrs. Aline B. Auerbach, Director, Parent Group Education Department, Child Study Association of America, New York; chairman, NCSW Committee on Audio-Visual Aids

"How Much Affection?" Mental Health Materials Center, 104 East 25th Street, New York 10, N.Y.

"When Should I Marry?" Mental Health Materials Center, 104 East 25th Street, New York 10, N.Y.

Panel members: Dorothy Westby-Gibson, Assistant Professor of Education and Psychology, San Francisco State College; Mrs. Sallie M. Edwards, Associate Executive Director, YWCA, San Francisco

Committee on Audio-visual Aids. Urban Renewal

Presiding: Malvin Morton, Executive Director, Chicago Federation of Settlements and Neighborhood Centers

"City in a Shadow." WBZ-TV, 1170 Soldiers Field Road, Boston 34, Mass.

Floor discussion

WEDNESDAY, MAY 27

9:15 A.M.–10:45 A.M.

General Session. Nature and Scope of the Medical Care Problem in the United States

Presiding: George S. Stevenson, M.D., National and International Consultant, National Association for Mental Health, New York; member, Executive Committee, National Conference on Social Welfare

Introduction of representatives of State Conferences of Social Work
Speaker: Herman M. Somers, Chairman, Department of Political Science, Haverford College, Haverford, Pa.

11:15 A.M.–12:45 P.M.

Section I. Services to Individuals and Families

GROUP MEETING 1. PUBLIC ASSISTANCE MEDICAL CARE PROGRAMS
Presiding: Thomas B. McKneely, M.D., Consultant on Medical Care, Bureau of Public Assistance, U.S. Department of Health, Education and Welfare, Washington, D.C.
From the Viewpoint of State Agency Administration
Speaker: James A. Stewart, M.D., Medical Consultant, Oregon Public Welfare Commission, Portland
From the Viewpoint of Local Agency Operations
Speaker: Harold M. F. Behneman, M.D., Chief of Medical Services, San Diego County Department of Public Welfare, San Diego, Calif.
From the Viewpoint of the Medical Social Worker
Speaker: Pearl Bierman, Medical Consultant, American Public Welfare Association, Chicago
From the Viewpoint of Organized Medicine
Speaker: Nelson Neff, Executive Secretary, Nevada State Medical Association, Reno
Floor discussion

GROUP MEETING 2. MEDICAL ASPECTS OF REHABILITATION
Presiding: Sidney S. Norwick, M.D., member, San Leandro Medical Group, San Leandro, Calif.; formerly Regional Medical Consultant, Office of Vocational Rehabilitation, U.S. Department of Health, Education, and Welfare, San Francisco
Advances in Rehabilitation in a Large Chronic Disease Hospital
Speaker: John E. Affeldt, M.D., Medical Director, Respiratory Center for Poliomyelitis, Rancho Los Amigos Hospital, Los Angeles County Department of Charities, Hondo, Calif.
Rehabilitation in a Small County General Hospital
Speaker: Lillian Wurzel, Supervisor, Social Services, Contra Costa County Hospital, Martinez, Calif.
Discussion leader: David Frost, M.D., Medical Consultant, Office of Vocational Rehabilitation, U.S. Department of Health, Education, and Welfare, San Francisco
Floor discussion

GROUP MEETING 3. (CO-SPONSORING GROUP: SECTION III, GROUP MEETING 2.) TOTAL CARE OF PATIENTS WITH LONG-TERM ILLNESS: TRENDS AND BASIC ISSUES

Presiding: Mrs. Bertram Low-Beer, President, Board of Directors, Chronic Illness Service, San Francisco

Speaker: Lester Breslow, Chief, Bureau of Chronic Diseases, California State Department of Public Health, Berkeley

Discussants: DeWitt K. Burnham, M.D., Associate Clinical Professor, Stanford Medical School; member, Board of Directors, San Francisco Chronic Illness Service Center; Chief of Staff, Garden Hospital, San Francisco; Mrs. Arnoldine Ickes, Medical Services Supervisor, San Francisco Area Office, California State Department of Social Welfare, San Francisco

GROUP MEETING 4. MENTAL HEALTH SERVICE—INTERDISCIPLINARY CO-OPERATION

Presiding: Nathan Sloate, Chief of Social Service, California State Department of Mental Hygiene, Sacramento

Speaker: John Skinner, psychiatric social worker in private practice, Los Angeles

Discussants: Norman Reider, M.D., Senior Psychiatrist, Mt. Zion Psychiatric Clinic, San Francisco; Max Bogner, Supervising Psychiatric Social Worker, Bureau of Social Work, California State Department of Mental Hygiene, Sacramento

Floor discussion

GROUP MEETING 5. NEW KNOWLEDGE IN THE TREATMENT OF ALCOHOLISM

Presiding: John R. Philp, M.D., Chief, Division of Alcoholic Rehabilitation, California State Department of Public Health, Berkeley

Alcoholism Is Everybody's Problem

Speaker: John R. Philp, M.D.

Treatment Is Not Enough

Speaker: Arpad Kertesz, Chief Social Worker, Sacramento County Alcoholic Rehabilitation Clinic, Sacramento

Combined Individual, Joint, and Group Therapy in the Treatment of Alcoholism

Speaker: Mrs. Florence Preston, social worker, Adult Guidance Center, Department of Public Health, City and County of San Francisco

Discussant: Mrs. Esther Spencer, Chief, Bureau of Medical Social Services, California State Department of Public Health, Berkeley

Floor discussion

Section II. Services to Groups and Individuals in Groups

GROUP MEETING 1. SERVICES TO THE PHYSICALLY HANDICAPPED

Presiding: Jeannette Deaver, Executive Director, Oakland Area Girl Scout Council, Calif.

The National Picture

Speaker: Edith P. Sappington, M.D., Regional Medical Director, Children's Bureau, U.S. Department of Health, Education, and Welfare, San Francisco

Overcoming Social Isolation through a Peer Group Experience—Some Fundamental Issues in Group Work for the Physically Handicapped Child in His Own Neighborhood

Speaker: Ralph L. Kolodny, Research Supervisor, Department of Neighborhood Clubs, Boston Children's Service Association

Floor discussion

GROUP MEETING 2. MULTIDISCIPLINE METHODS OF WORK WITH CONVALESCENT PATIENTS RELEASED FROM PSYCHIATRIC HOSPITAL

Presiding: Marion B. Sloan, School of Social Work, University of Southern California, Los Angeles

Multidiscipline Methods of Work with Convalescent Patients Released from Psychiatric Hospital

Speakers: David Kahn, Supervisor, Bureau of Social Work, California State Department of Mental Hygiene, San Francisco
Mrs. Dorothea Cudaback, Acting Supervising Social Worker, San Mateo Mental Health Extension Services, San Mateo, Calif.

The Social Work Role in Hospital and Community in an Interdisciplinary Program to Rehabilitate Mentally Ill Geriatric Patients

Speaker: David Freeman, Supervising Psychiatric Social Worker, Metropolitan State Hospital, Norwalk, Calif.

Floor discussion

GROUP MEETING 3. MOBILIZING ACTION FOR MEDICAL CARE

Presiding: Mrs. Carl Goldmark, Jr., New York; secretary, Manhattanville Community Centers; Treasurer, National Federation of Settlements and Neighborhood Centers

Speaker: James Brindle, Director, Social Security Service Department, United Automobile Workers, AFL-CIO, Detroit

Discussants: Bernard M. Shiffman, Executive Secretary, Division on Recreation and Informal Education, Welfare Council of Metropolitan Chicago; Mrs. Francis E. McMahon, Executive Director, Illinois Child Labor Committee, Chicago

Floor discussion

Section III. Services to Agencies and Communities

GROUP MEETING 1. IMPLICATIONS FOR COMMUNITY PLANNING OF FINANCING VOLUNTARY HEALTH AGENCY PROGRAMS

Presiding: Philip E. Ryan, Executive Director, National Health Council, New York

Speakers: Lyman S. Ford, Associate Executive Director, United Community Funds and Councils of America, New York
Melvin A. Glasser, Executive Vice President, National Foundation, New York

GROUP MEETING 2. (JOINT MEETING WITH SECTION I—GROUP MEETING 3.) TOTAL CARE OF PATIENTS WITH LONG-TERM ILLNESS: TRENDS AND BASIC ISSUES

Committee on Audio-visual Aids. New Approaches to Hospital Care for Children

Presiding: Jules Levaggi, social worker, Family Service Agency of San Francisco

"Going to Hospital with Mother." New York University Film Library, 26 Washington Place, New York 3, N.Y.

Discussant: Mrs. Aline B. Auerbach, Director, Parent Group Education Department, Child Study Association of America, New York; chairman, Committee on Audio-Visual Aids

Floor discussion

1:15 P.M.–2:00 P.M.

Committee on Audio-visual Aids. Improving Medical Care around the World

"People like Maria." Center for Mass Communication, Columbia University Press, 1125 Amsterdam Avenue, New York 25, N.Y.

2:00 P.M.–3:30 P.M.

Committee on Planning Meetings in Social Welfare. Planning Meetings on Controversial Issues

Presiding: Mrs. Kathleen Zurbucken, Executive Secretary, Family Service and Guidance Center, Topeka, Kans.; Vice Chairman, Committee on Planning Meetings in Social Welfare

Speakers: Robert Haas, Head, General Instruction, Arts and Humanities, University of California, Los Angeles
Mrs. Eva Schindler-Rainman, School of Social Welfare, University of California, Los Angeles

Floor discussion

Committee on Public Relations. The Catching of the Conscience

Presiding: Harold Weiner, Executive Director, National Publicity Council for Health and Welfare Services, New York

Speaker: Joseph H. Bunzel, Associate Professor of Social Research, Richmond Professional Institute, College of William and Mary, Richmond, Va.

Committee on Social Research

GROUP MEETING 1. NEEDED RESEARCH IN MEDICAL CARE

Presiding: Bernard Finkelstein, Associate Director, United Fund of El Paso, El Paso, Texas

Speaker: Odin W. Anderson, Research Director, Health Information Foundation, New York

Discussant: Wilbur S. Cohen, Professor of Public Welfare Administration, School of Social Work, University of Michigan, Ann Arbor

GROUP MEETING 2. HOME MEDICAL CARE IN SAN FRANCISCO

Presiding: Mrs. Helene M. Lipscomb, Executive Director, Chronic Illness Service Center of San Francisco

Panel members: Mark Berke, Director, Mount Zion Hospital, San Francisco; Harry Weinstein, M.D., Medical Director, Home Medical Care of San Francisco; Alice Gonnerman, Coordinator, Home Medical Care of San Francisco

Floor discussion

GROUP MEETING 3. INTENSIVE GROUP WORK WITH SERIOUSLY DISABLED ADULTS, RESEARCH STUDY

Panel chairman: W. Karl Rehfeld, Supervisor, Intensive Casework Unit, Lake County Department of Public Welfare, Gary, Ind.

Panel members: Morris L. Eisenstein, Executive Director, Glenwood Community Center, Brooklyn, N.Y.; Shirley London, caseworker, Muscular Dystrophy Association, Brooklyn, N.Y.; Mrs. Fannie Eisenstein, group and research worker, Glenwood Community Center, Brooklyn, N.Y.

Committee on Audio-visual Aids. Methods of Financing Medical Care

Presiding and discussion leader: E. R. Weinerman, M.D., Medical Director, Herrick Memorial Hospital Clinics; Medical Consultant, West Coast Union Health and Welfare Programs, El Cerrito, Calif.

"On This Day." Health Insurance Plan of Greater New York, 625 Madison Avenue, New York 22, N.Y.

"Second Sight Sam." Association Films, Ridgefield, N.J.

"Our Nation's Health." Department of Education, AFL-CIO, 815 16th Street, N.W., Washington 6, D.C.

Discussants: Beryl Roberts, Associate Professor of Health Education, School of Public Health, University of California, Berkeley; Mrs. Veryl Lewis, District Supervisor, Contra Costa County Social Service Department, Richmond, Calif.

Floor discussion

4:00 P.M.–5:30 P.M.

National Conference on Social Welfare. You and the Annual Forum
Presiding: Robert H. MacRae, President, National Conference on Social Welfare
Speakers: Robert H. MacRae
David G. French, Florence Heller School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass.; chairman, National Conference on Social Welfare Study Commission
Joe R. Hoffer, Executive Secretary, National Conference on Social Welfare, Columbus, Ohio

8:30 P.M.

General Session. How Shall We Provide Medical Care for All Who Need It?
Presiding: Robert H. MacRae, President, National Conference on Social Welfare
Speakers: Malcolm S. M. Watts, M.D., Assistant Dean and Assistant Clinical Professor of Medicine, University of California School of Medicine; also in the private practice of medicine
Russell V. Lee, M.D., executive of the Palo Alto (Calif.) Medical Clinic; also in the private practice of internal medicine

THURSDAY, MAY 28

9:15 A.M.–10:45 A.M.

Combined Associate Group Meeting. New Trends in Adoption Practice
Presiding: Helen Fradkin, Child Welfare League of America, New York
Panel members: Mrs. Amelia Igel Sternau, Director, Child Adoption Service, State Charities Aid Association, New York; Allen Neubauer, chairman, Adoption Division, Boys and Girls Aid Society of Oregon, Portland; Richard L. Mayers, Deputy State Attorney General of California, Sacramento, Calif.
Floor discussion

Combined Associate Group Meeting. Facing the Realities of Providing Social Work Education
Presiding: Robert F. Fenley, Director of Personnel, United Community Funds and Councils of America, New York
Speaker: Ann Elizabeth Neely, Consultant on Program Services, Council on Social Work Education, New York
Discussants: Lloyd Dinkelspiel, President, National Jewish Welfare Board, San Francisco; Emil Sunley, Director, School of Social

Work, University of Denver; Mrs. Louise Mumm, Staff Consultant, National Social Welfare Assembly, New York; Glenn Hayworth, student, School of Social Welfare, University of California, Berkeley

Floor discussion

Combined Associate Group Meeting. Implications of the American Heritage

Presiding: Peter L. Sandi, School of Social Welfare, University of California at Los Angeles

Speaker: Ralph L. Beals, School of Anthropology, University of California, Los Angeles

Discussants: Winifred Smith, Chief Casework Supervisor, Home Service Department, Los Angeles Red Cross

Floor discussion

Combined Associate Group Meeting. Planning Community Services in Today's Social Scene

Presiding: Margaret Berry, Executive Director, National Federation of Settlements and Neighborhood Centers, New York

Social Welfare's Task in the Present Social Revolution

Speakers: Louis Miniclier, Chief, Community Development Division, Office of Public Services, International Cooperation Administration, Washington, D.C.

Charles G. Chakerian, Professor of Church and Community, McCormick Theological Seminary, Chicago

Combined Associate Group Meeting. Professional-Volunteer-Client Interrelationships

Presiding: Marjorie A. Collins, Director, Central Volunteer Bureau, Community Council of Greater New York

Speakers: Eulene Hawkins, Home Service Director, American Red Cross, District of Columbia Chapter, Washington, D.C.

Goesta Wollin, Executive Director, Big Brothers of America, Philadelphia

Floor discussion

Committee on Audio-visual Aids. New Approaches to Work with Criminal Offenders

Presiding: Austin MacCormick, Professor of Criminology, University of California, Berkeley

"Face of Crime." Reach, McClinton & Co., 505 Park Avenue, New York, N.Y.

Discussant: Samuel Susselman, M.D., Assistant Clinical Professor

of Psychiatry, Langley Porter Neuropsychiatric Institute, University of California Medical College, San Francisco

Floor discussion

11:15 A.M.–12:45 P.M.

Combined Associate Group Meeting. Intercountry Adoptions

Presiding: Lucile Kennedy, Chief, Division of Child Welfare, California State Department of Social Welfare, Sacramento

Speaker: Mildred Arnold, Director, Division of Social Services, Children's Bureau, Social Security Administration, U.S. Department of Health, Education, and Welfare, Washington, D.C.

Discussant: Mrs. Roberta Rindfleisch, Director of Child Welfare, Minnesota State Department of Public Welfare

Floor discussion

Combined Associate Group Meeting. Professional–Volunteer–Client Interrelationships

Presiding: Marjorie A. Collins, Director, Central Volunteer Bureau, Community Council of Greater New York

Speakers: Eli Levy, social group worker, Hillside Hospital, Glen Oaks, N.Y.

Margaret Ryan, Director of Membership and Leadership Service, YWCA, Oakland, Calif.

Floor discussion

Combined Associate Group Meeting. Facing the Realities of Providing Social Work Education

Combined Associate Group Meeting. Concepts of Income Adequacy: Implications for Public Assistance

Presiding: Mrs. Azile H. Aaron, Regional Representative, Bureau of Public Assistance, U.S. Department of Health, Education, and Welfare, San Francisco

Present-Day Concepts of Income Adequacy

Speaker: Mrs. Helen H. Lamale, Chief, Branch of Consumption Studies, Bureau of Labor Statistics, U.S. Department of Labor, Washington, D.C.

Implications for Public Assistance

Speaker: Nathan E. Cohen, Dean, School of Applied Social Sciences, Western Reserve University, Cleveland

Combined Associate Group Meeting. Planning Community Services in Today's Social Scene

Presiding: Sidney Dillick, Executive Director, Rhode Island Council of Community Service, Providence

Current Issues in Community Planning

Panel members: Howard F. Gustafson, Executive Director, Health-Welfare Council of Indianapolis and Marion County; Jack Stumpf, Executive Director of San Bernardino County Council of Community Services, San Bernardino, Calif.; Meyer Schwartz, School of Social Work, University of Pittsburgh

Combined Associate Group Meeting. Implications of the American Heritage

Presiding: Nathalie Kennedy, University of California Medical Center, Los Angeles

Our Immigration Policy

Speaker: William S. Bernard, Co-Director, American Council for Nationalities Service, New York

Social Integration and Use of Minority Leadership

Speaker: Lewis G. Watts, Executive Director, Urban League of Seattle

Training of Social Workers

Speaker: Peter L. Sandi, School of Social Welfare, University of California, Los Angeles

Floor discussion

Committee on Audio-visual Aids. Interpreting the Constitution

Presiding: Edward L. Barrett, Jr., Law School, University of California, Berkeley

"The Constitution and the Right to Vote," Center for Mass Communication of Columbia University Press, 1125 Amsterdam Avenue, New York 25, N.Y.

"The Constitution and Military Power." Center for Mass Communication of Columbia University Press, 1125 Amsterdam Avenue, New York 25, N.Y.

1:00 P.M.–2:00 P.M.

Committee on Audio-visual Aids.

"The Adventures of * ", Edward Harrison, 1501 Broadway, New York, N.Y.

Committee on Audio-visual Aids. Interpreting Special Disabilities and Diseases

"Help for Young Hearts." American Heart Association, 44 East 23d Street, New York 10, N.Y.

"Never Alone." American Cancer Society, 521 West 57th Street, New York 19, N.Y.

"The Other Half of the Team." Muscular Dystrophy Associations of America, 1790 Broadway, New York 19, N.Y.

"Room for Recovery." The Seeing Eye, Morristown, N.J.

4:00 P.M.–6:00 P.M.

Committee on Audio-visual Aids. Feature Film
"Pather Panchali." Edward Harrison, 1501 Broadway, New York 36, N.Y.

FRIDAY, MAY 29

9:15 A.M.–10:45 A.M.

Section I. Services to Individuals and Families

GROUP MEETING 1. (JOINT SESSION WITH SECTION III.) IMPLICATIONS OF CURRICULUM STUDY SPONSORED BY COUNCIL ON SOCIAL WORK EDUCATION

GROUP MEETING 2. NEW APPROACHES TO THE ADMINISTRATION OF AID TO DEPENDENT CHILDREN

Presiding: Mrs. Barbara C. Coughlan, Director, Nevada State Welfare Department, Reno
Speakers: Jay L. Roney, Director, Bureau of Public Assistance, Social Security Administration, U.S. Department of Health, Education, and Welfare, Washington, D.C.
Kermit T. Wiltse, School of Social Welfare, University of California, Berkeley
Discussant: Thomas Bell, Director, Kern County Department of Welfare, Bakersfield, Calif.

GROUP MEETING 3. THE ROLE OF THE CHURCH IN SOCIAL WELFARE

Presiding: Alfred F. Angster, Executive Director, Lutheran Social Service, Augustana Central Conference, Chicago
Speaker: William J. Villaume, Executive Director, Department of Social Welfare, National Council of Churches of Christ in the U.S.A., New York
Discussants: Very Rev. Msgr. Raymond J. Gallagher, Assistant Director, Catholic Charities Bureau, Cleveland; Louis Weintraub, Associate Executive Director, Jewish Welfare Federation, San Francisco

Section II. Services to Groups and Individuals in Groups (Joint session with Section III.)
Implications of Curriculum Study Sponsored by Council on Social Work Education

Section III. Services to Agencies and Communities (Co-sponsoring groups: Section I, Group Meeting 1, and Section II.)
Implications of Curriculum Study Sponsored by Council on Social Work Education

Presiding: Helen Wright, Pasadena, Calif.; chairman of Curriculum Committee, Council on Social Work Education; former Dean, School of Social Service Administration, University of Chicago

Speaker: Ernest Witte, Executive Director, Council on Social Work Education, New York

Discussant: Ruth E. Smalley, Dean, School of Social Work, University of Pennsylvania, Philadelphia

Committee on Audio-visual Aids. An Interpretation of Homemaker Service

Presiding: Eve Kneznek, Training Consultant, New York State Department of Social Welfare, Albany

"Home Again." Mental Health Film Board, 267 West 25th Street, New York 1, N.Y.

Floor discussion

11:15 A.M.–12:45 P.M.

Closing General Session. Social Welfare in the USSR Today

Presiding: Robert H. MacRae, President, National Conference on Social Welfare

Speaker: Charles I. Schottland, Dean, Florence Heller School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass.

Appendix B: Business Organization of the Conference for 1959

THE NATIONAL CONFERENCE ON SOCIAL WELFARE is a voluntary association of individual and organizational members who have joined the Conference to promote and share in discussion of the problems and methods identified with the field of social work and immediately related fields.

NATIONAL CONFERENCE ON SOCIAL WELFARE AND ASSOCIATE GROUPS

NCSW OFFICERS

President: Robert H. MacRae, Chicago
First Vice President: John Tramburg, Trenton, N.J.
Second Vice President: Joseph Bierne, Washington, D.C.
Third Vice President: Karl deSchweinitz, Washington, D.C.
Secretary: Jean Kallenberg, New York
Treasurer: Arch Mandel, Boston
Past President: Mrs. Eveline M. Burns, New York
President-Nominee: Charles I. Schottland, Waltham, Mass.
Executive Secretary: Joe R. Hoffer, Columbus, Ohio

NCSW EXECUTIVE COMMITTEE

Includes Officers Listed Above

Term expires 1959: Phyllis Burns, Ottawa, Canada; Thomas C. Desmond, Newburgh, N.Y.; Lyman S. Ford, New York; Victor I. Howery, Seattle; Mrs. Victor Shaw, Fairmont, W. Va.; Sue Spencer, Nashville, Tenn.; George Stevenson, M.D., New York

Term expires 1960: Harry M. Carey, Boston; Bill Child, Boise, Idaho; Wilbur J. Cohen, Ann Arbor, Mich.; David French, Waltham, Mass.; Clara Kaiser, New York; Mrs. Justine Wise Polier, New York; Karl Stern, M.D., Montreal, Canada

Term expires 1961: Clark W. Blackburn, New York; Daniel Blain, M.D., Sacramento, Calif.; Sidney Hollander, Baltimore; Hugh R.

Jones, Utica, N.Y.; William T. Kirk, New York; Gisela Konopka, Minneapolis; Sister Mary Immaculate, San Antonio, Texas

NCSW COMMITTEE ON NOMINATIONS

Chairman: Sol Morton Isaac, Columbus, Ohio

Term expires 1959: Margaret Adams, New York; Roger Cumming, Washington, D.C.; Arthur E. Fink, Chapel Hill, N.C.; Sol Morton Isaac, Columbus, Ohio; Leah James, Chattanooga, Tenn.; Mrs. Jane W. McKaskle, San Francisco; Violet M. Sieder, New York

Term expires 1960: Helen M. Alvord, Greenwich, Conn.; Mildred Arnold, Washington, D.C.; H. E. Chamberlain, M.D., Sacramento, Calif.; Dorothy B. Ferebee, M.D., Washington, D.C.; Mrs. Frances Goodall, Chicago; Esther Test, Cleveland; Cecile M. Whalen, Washington, D.C.

Term expires 1961: Paul V. Benner, Baton Rouge, La.; Pearl Bierman, Chicago; Ernest J. Bohn, Cleveland; Bess Craig, Chicago; Merrill Krughoff, New York; Ralph Ormsby, Philadelphia; Jane Sutherland, New York

NCSW PROGRAM COMMITTEE

Members-at-Large

Term expires 1959: Mrs. Robert L. Foote, Glencoe, Ill.; John Kidneigh, Minneapolis

Term expires 1960: Mrs. Moise Cahn, New Orleans; John McDowell, Boston

Term expires 1961: Nelson C. Jackson, New York; Mrs. Ida C. Merriam, Washington, D. C.

NCSW SECTION COMMITTEES

SECTION I. SERVICES TO INDIVIDUALS AND FAMILIES

Chairman: Ronald H. Born, San Francisco

Vice Chairman: Manuel Kaufman, Philadelphia

Term expires 1959: Alfred Angster, Chicago; Shelton Granger, Minneapolis; Eva Hance, San Francisco; Jerome Kaplan, Mansfield, Ohio; Joseph R. Morrell, Jr., San Francisco; Marion Murphy, Minneapolis

Term expires 1960: Mrs. Margaret D. Brevoort, Milwaukee; Mrs. Edwin J. Kuh, Jr., Highland Park, Ill.; Ben S. Meeker, Chicago; Mary A. Young, Chicago

Term expires 1961: Marvin Cardoza, San Francisco; Ruth Cooper, Berkeley; Arthur R. Hellender, Oakland, Calif.; Andrew F. Juras, Portland, Oreg.; Harold E. Simmons, San Mateo, Calif.

SECTION II. SERVICES TO GROUPS AND INDIVIDUALS IN GROUPS

Chairman: Mrs. Jane E. Costabile, Detroit

Vice Chairman: Mrs. J. Howard Stephenson, Riverside, Ontario, Canada

Term expires 1959: Ruth Buckwalter, Detroit; Jeannette Deaver, Oakland, Calif.; John Q. Douglas, Augusta, Maine; Abraham Kestenbaum, Detroit; Richard Lodge, Haverstown, Pa.; Walter B. Miller, Roxbury, Mass.; Robert D. Vinter, Jr., Ann Arbor, Mich.

Term expires 1960: Elizabeth A. Campbell, Philadelphia; Helen E. Heydrick, Philadelphia; Bernard R. Marks, Philadelphia; Dorothy J. Royce, Upper Darby, Pa.

Term expires 1961: Virginia Lee Crowthers, Grosse Pointe Woods, Mich.; Mark K. Herley, Detroit; Emeric Kurtagh, Detroit; Olga M. Mader, Detroit

SECTION III. SERVICES TO AGENCIES AND COMMUNITIES

Chairman: Joseph H. Reid, New York

Vice Chairman: Mrs. Cecile R. Sands, Brooklyn, N.Y.

Term expires 1959: James H. Bond, Dallas; Mrs. Moise Cahn, New Orleans; Walter Kindelsperger, New Orleans

Term expires 1960: H. Aubrey Elliott, Austin, Texas; Jessie B. Johnson, Denver, Mrs. Louis A. Pollock, Denver; Mrs. Margaret Rule, Oklahoma City

Term expires 1961: Margaret Berry, New York; Mrs. Irene Farnham Conrad, New York; Katharine D. Harvey, New York; John G. Hill, New York

NCSW COMMON SERVICE COMMITTEES

COMMITTEE ON PLANNING MEETINGS IN SOCIAL WELFARE

Chairman: Joseph Meisels, Kansas City, Kans.

Vice Chairman: Mrs. Kathleen Zurbuchen, Topeka, Kans.

Term expires 1959: Roger Cumming, Washington, D.C.; Ethel James–Williams, Washington, D.C.; Joseph Levering, Washington, D.C.; Florence Murray, Washington, D.C.; Helaine Todd, Washington, D.C.

Term expires 1961: Mrs. Freda Burnside, San Francisco; Edward Parsons, Jefferson City, Mo.; Alfred E. Poe, Kansas City, Mo.; B. W. Tucker, Carbondale, Ill.; Homer Wadsworth, Kansas City, Mo.

COMMITTEE ON PUBLIC RELATIONS

Chairman: Mrs. Frances Schmidt, Harrisburg, Pa.

Vice Chairman: Stephen L. Nelson, Savannah, Ga.

Term expires 1959: Clyde Getz, Los Angeles; Margaret Mudgett,

Los Angeles; Mrs. Jean Shores, Los Angeles; Heman Stark, Sacramento, Calif.

Term expires 1961: Frankie V. Adams, Atlanta; Harry Boyte, Atlanta; Wellborn R. Ellis, Atlanta; George E. Rice, Augusta; Nelson Stephenson, Raleigh, N.C.

COMMITTEE ON SOCIAL RESEARCH AND SOCIAL STUDIES

Chairman: Fred Steininger, Gary, Ind.

Vice Chairman: Sidney E. Zimbalist, Indianapolis

Term expires 1959: Joseph Eaton, Los Angeles; Mary L. Fisher, Gary, Ind.; Dr. Bertha M. Luckey, Cleveland; Mrs. Florence G. McDaniel, Indianapolis; Dr. Howard M. Wells, East Cleveland

Term expires 1961: Evelyn G. Bell, Indianapolis; G. Harold Duling, Indianapolis; Wesley A. Dunn, Indianapolis; Melville Hosch, Chicago; Walter B. Johnson, Indianapolis

NCSW COMMITTEE ON AUDIO-VISUAL AIDS

Chairman: Mrs. Aline B. Auerbach, New York

Vice Chairman: Martha Winn, New York

Term expires 1959: Erik Barnouw, New York; John S. Blum, San Mateo, Calif.; Margaret Carter, New York; Eva Kneznek, Albany, N.Y.; Irving S. Shapiro, New York; Harold Weiner, New York

Term expires 1960: O. H. Coelln, Chicago; Robert Finehout, New York; Agnes Jones, New York; Rohama Lee, New York; Jules Levaggi, San Francisco

Term expires 1961: Robert Disraeli, New York; Margaret Kahn, New York; Malvin Morton, Chicago; Mrs. Mildred Rabinow, New York; Alex Rosen, New York; Mrs. Helen F. Southard, New York; Alfred V. Taylor, New York; Mrs. Margaret G. Twyman, New York

NCSW EDITORIAL COMMITTEE

Chairman: Emanuel Berlatsky, New York

Walter Friedlander, San Francisco; Gordon Hamilton, New York

SELECTION COMMITTEE FOR CASEWORK PAPERS, 1959

Chairman: Henry Maas, Berkeley, Calif.

Nellie Woodward, San Francisco; Elizabeth B. MacLatchie, Sacramento, Calif.

SELECTION COMMITTEE FOR GROUP WORK PAPERS, 1959

Chairman: Helen Northen, Los Angeles

Gladys Ryland, Berkeley, Calif; Florence Scott, San Francisco

SELECTION COMMITTEE FOR COMMUNITY ORGANIZATION PAPERS, 1959

Chairman: Seaton Manning, San Francisco
Eva Hance, San Francisco; Ralph Kramer, San Francisco

STAFF PERSONNEL COMMITTEE

Chairman: Mrs. Victor Shaw, Fairmont, W. Va.
Russell Leedy, Columbus, Ohio; Meyer Schwartz, Columbus, Ohio

COMMITTEE ON COMBINED ASSOCIATE GROUP MEETINGS

Chairman: Herbert Millman, National Jewish Welfare Board

American Council for Nationalities Service, William S. Bernard; American Home Economics Association, Martha Rogin; American Jewish Committee, Samuel Fishzohn; Child Study Association of America, Alfred D. Buchmueller; Council on Social Work Education, Ann Elizabeth Neely; International Social Service, American Branch, Mrs. Susan T. Pettiss; National Association for Retarded Children, Manford Hall; National Association of Social Workers, School Social Work Section, Richard F. Mastronarde; National Legal Aid Association, Junius L. Allison; National Publicity Council for Health and Welfare Services, Harold Weiner

PROGRAM CHAIRMEN OF COMBINED ASSOCIATE GROUP MEETINGS

Aging in Today's World
Mrs. Frank M. Barry, Director, Department of Work with Older Persons, Cleveland Welfare Federation

Family Life Education
Bertram H. Gold, Executive Director, Jewish Centers Association, Los Angeles

Serving the Serviceman and Seaman
Genevieve Gabower, social worker, U.S. Naval Hospital, Bethesda, Md.

People, Housing, and Social Work
Reginald Johnson, National Urban League, New York

Understanding Group Dynamics in the Learning Process
Charlotte Johnson, Assistant National Director, Disaster Services, American National Red Cross, Washington, D.C.

Social Services to Former Mental Patients
Edward Linzer, Director of Education Services, National Association for Mental Health, New York

The 1960 White House Conference on Children and Youth
William J. Villaume, Executive Director, Church Conference of Social Work, New York

Community Responsibility, Planning and Action to Provide Jobs for Hard-to-Place Youth
Eli E. Cohen, Executive Secretary, National Child Labor Committee, New York

New Knowledge about the Mentally Retarded
Gunnar Dybwad, Executive Director, National Association for Retarded Children, New York

Social Work Training around the World
Anna King, Fordham School of Social Service, New York

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